

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pupers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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30M REV. 1968

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14812

CERTIFICATE OF DEATH

14820

1. DECEASED-NAME (Type or print) <b>Frances Pearl Anderson</b>			2a. DATE OF DEATH Month <b>Oct.</b> Day <b>8</b> Year <b>1968</b>			2b. HOUR <b>10 P.M.</b>				
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>6-5-08</b>			6. AGE (In years lost birthday) <b>60</b> YRS.			
7a. BIRTHPLACE (State or foreign country) <b>Michigan</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George's</b> Md.				
10. CITY OR TOWN OF DEATH <b>Cheverly</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo.Gen'l Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during preceding 12 months, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Prince George's</b>		13c. CITY OR TOWN <b>Suitland</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>4830 Homer Ave.</b>	
14. FATHER'S NAME First Middle Last <b>William Page</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Cora (Unknown)</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <b>NO</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT Address <b>Arthur W. Anderson, same as #13 (Husband)</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4270 Left lower lobe bronchopneumonia.</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Congestive heart failure.</b> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4341 Surgical absence of right lung and right breast.</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) <del>(this hospital)</del> attended the deceased from <b>Sept. 1950</b> to <b>Oct. 8, 1968</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>Oct. 8, 1968</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death.										
22b. SIGNATURE <b>William Brainin</b>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>Oct. 9, 1968</b>		
22d. PHYSICIAN'S NAME (Type) <b>William Brainin, M. D.</b>						22e. ADDRESS <b>6056 Central Ave., Capital Hgts. Md. 20027</b>				
23a. BURIAL, CREMATION, REMOVAL (City) <b>Burial</b>			23b. DATE <b>10-12-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland, Maryland</b>			
24. FUNERAL DIRECTOR <b>Wilhelm Funeral Home</b> ADDRESS <b>4308 Suitland Rd. SE, Washington, D.C.</b>						25a. REC'D BY REGISTRAR DATE <b>OCT 14 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



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Charles George Attick  
 398X  
 1968

110

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MEDICAL CERTIFICATION

14812		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				14821	
1. DECEASED-NAME (Type or print) <b>GEORGE</b>			First <b>W</b>		Last <b>Attick</b>		2a. DATE OF DEATH Month <b>Oct</b> Day <b>21</b> Year <b>1968</b>
3. SEX <b>Male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>9/17/15</b>		6. AGE (In years lost birthday) <b>53</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Md</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George's</b> Md.	
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Pro Georges Hospt</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Accountant</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U S Government</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md</b>		13b. COUNTY <b>Pro Geo.</b>		13c. CITY OR TOWN <b>College Ht</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First <b>Charles M</b> Middle <b>Attick</b> Last <b></b>		15. MOTHER'S MAIDEN NAME First <b>Lillian L</b> Middle <b>Bursey</b> Last <b></b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>no</b>		16b. SOCIAL SECURITY NO. <b>216 44 7728</b>		17. INFORMANT <b>Helen T Attick</b> Address <b>College Heights Estates, Md</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Failure</b> 398X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Rheumatic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>25yr +</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>410x</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>1950</b> , 19 <b>68</b> , to <b>1968</b> , 19 <b>68</b> , that (I) <del>(was)</del> lost saw the deceased alive on <b>Aug 16</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) <del>(do)</del> view the body after death.							
22b. SIGNATURE <b>U-L Etienne</b>		22c. DATE SIGNED <b>10/4/68</b>		22d. PHYSICIAN'S NAME (Type) <b>U-L ETIENNE</b>			
22e. ADDRESS <b>College Park, Md</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10/24/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor Pro Geo Md</b>	
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 25 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

14621

14621

ATTN: Mr. J. H. ...

George

Point Hypocentral Failure  
Rheumatic Head Failure  
2742 +

1958

1970

Page 2

W. C. ETIENNE  
W. C. ETIENNE

College Park Md  
10/1/07

1967



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

14814

14822

1. DECEASED-NAME (Type or print) <del>HELEN</del> <sup>First</sup> GERTRUDE <sup>Middle</sup> HELEN <sup>Last</sup> BAILEY			2a. DATE OF DEATH Month Day Year 10-4-68			2b. HOUR 8:55 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 3-27-94		6. AGE (In years last birthday) 74 YRS.	
7a. BIRTHPLACE (State or foreign country) Penna.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md.	
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Leland Memorial Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housekeeper		12b. KIND OF BUSINESS OR INDUSTRY DOMESTIC	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Penna.		13b. COUNTY ELK		13c. CITY OR TOWN Kersey		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER		14. FATHER'S NAME <sup>First</sup> TERRANCE <sup>Middle</sup> <sup>Last</sup> BROWN		15. MOTHER'S MAIDEN NAME <sup>First</sup> ROSE <sup>Middle</sup> <sup>Last</sup> ADAMS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO. 178-22-9666		17. INFORMANT Address 1820 BUENA VISTA DRIVE MRS W.M. BROWN EGGLED, OHIO			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Hemorrhage</u> 4120 DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Intense cerebral hemorrhage O.V. blood</u> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 443X							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat white <input type="checkbox"/> at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>July 2</u> , 19 <u>68</u> , to <u>July 4</u> , 19 <u>68</u> , that (I) <u>we</u> lost saw the deceased alive on <u>July 4</u> , 19 <u>68</u> , and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>we</u> (did) (did not) view the body after death.							
22b. SIGNATURE <u>Robert C. Wingfield</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <u>Oct 5, 1968</u>			
22d. PHYSICIAN'S NAME (Type) ROBERT C. WINGFIELD				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10-8-68		23c. NAME OF CEMETERY OR CREMATORY St Boniface Cem		23d. LOCATION (City or Town) (County) (State) Kersey Elk Penn.	
24. FUNERAL DIRECTOR <u>De Witt Donaldson</u>				25a. REC'D BY REGISTRAR DATE OCT 8 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

14823

1. DECEASED NAME (Type or print)		First <b>ALVA</b>		Last <b>E. BARNES, SR.</b>		2a. DATE OF DEATH Month <b>OCT</b> Day <b>4</b> Year <b>1968</b>		2b. HOUR <b>9 P. M.</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>JAN. 3, 1905</b>		6. AGE (In years last birthday) <b>63</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>PRINCE GEORGES</b> Md			
10. CITY OR TOWN OF DEATH <b>W. HYATTSVILLE</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>6632 24th AVE</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>AUTO MECHANIC</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>SAME</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>		13b. CITY OR TOWN <b>PR. GEO</b>		13c. CITY OR TOWN <b>W. HYATTS.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>6632 24th AVE</b>	
14. FATHER'S NAME First Middle Last <b>Barnes</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>John Ymazon</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>Yes</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. Adair R. Barnes</b> Address <b>6632-24th</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>1890</b> IMMEDIATE CAUSE (a) <b>Hypernephroma right kidney with</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>metastases to lungs &amp; brain</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>180x</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>May</b> , 19 <b>68</b> , to <b>Oct 4</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>Oct 4</b> , 19 <b>68</b> , and that is (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Ermo P. Ingel MD</b>		22c. DATE SIGNED <b>Oct 4, 1968</b>		22d. PHYSICIAN'S NAME (Type) <b>ERMO P. INGEL</b>					
22e. ADDRESS <b>1905 Queens Chapel Rd Wash DC 20008</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>Oct. 7. 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dec. Washington Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Adelphi On Dec. Md</b>			
24. FUNERAL DIRECTOR <b>John H. Hatter, 254 Carroll St NW Wash DC</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 8 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					



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14816										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										14824									
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR									
First Arthur Middle H Last Baxter										Month 29, Day 1968 Year										9:05A M									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years lost birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS														
Male			Caucasian			Dec 16, 1916			51 YRS			MONTHS DAYS			HOURS MIN														
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH																				
Md			U S A						Prince George's Md.																				
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY														
Cheverly					Prince Geo. Gen'l Hospital					Guard					P E P co														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE					13b. CITY OR TOWN					13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13d. STREET AND NUMBER														
Maryland					Prince George's Hyattsville										7522-A Hawthorne Sr.														
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME																								
First Middle Last					First Middle Last																								
George P Baxter					Sadie Robinson																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)					16b. SOCIAL SECURITY NO.					17. INFORMANT Address																			
W W 11					218 05 6778					Nell G Baxter Kentland, Md.																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1. Terminal Carcinoma															Jan. 1968														
1579 DUE TO, OR AS A CONSEQUENCE OF -																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of pancreas																													
DUE TO, OR AS A CONSEQUENCE OF (c) Metastasis to liver & duodenum																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
1578																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (the hospital) attended the deceased from Jan. 1968, to Oct. 29, 1968, that (I) (we) last saw the deceased alive on Oct. 29, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE															22c. DATE SIGNED														
22d. PHYSICIAN'S NAME (Type)															22e. ADDRESS														
Ohannes Sahakyan, M. D.															6001 Landover Rd., Cheverly, Md.														
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)														
Burial					Nov 1, 1968					Ft Lincoln Cemetery					Colmar Manor Pro Geo Md														
24. FUNERAL DIRECTOR ADDRESS															25a. REC'D BY REGISTRAR DATE					25b. REGISTRAR'S SIGNATURE									
F. Gasch's Sons Hyattsville, Md.															NOV 4 1968					Charles Judge									

2000

2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 2681, 2682, 2683, 26

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Printed by the Government Printer, Ottawa, Ontario.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
14817					14825					
1 DECEASED NAME (Type or print)					2a. DATE OF DEATH					
Earl Milton Bean					Oct. 23, 1968					
3 SEX					7b. AGE (In years lost birthday)					
Male					64 YRS.					
4. RACE					5 DATE OF BIRTH					
Caucasian					Sept. 17, 1904					
7a. BIRTHPLACE (State or foreign country)					9. COUNTY OF DEATH					
Md					Prince George's Md.					
7b. CITIZEN OF WHAT COUNTRY?					8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					
U S A										
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					
Cheverly					Prince Geo. Gen'l Hospital					
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)					12b. KIND OF BUSINESS OR INDUSTRY					
Retired Baker					Bakery					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE					13c. CITY OR TOWN					
Maryland					Riverdale					
13b. COUNTY					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>					
Prince George's										
13e. STREET AND NUMBER					14. FATHER'S NAME First Middle Last					
5703 Nicholson St.					Spencer Bean					
15. MOTHER'S MAIDEN NAME First Middle Last					16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)					
Ethel S Whipp					no					
16b. SOCIAL SECURITY NO.					17. INFORMANT Address					
578 09 6878					Naomi G. Bean East Riverdale, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Heredity Spino-cerebellar ataxia with coma;										
220 / DUE TO, OR AS A CONSEQUENCE OF right hemiplegia & aphasia.										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										
(b) DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)										
220 X										
MEDICAL CERTIFICATION										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
			P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from Oct 6, 1968, to Oct. 23, 1968, that (I) (we) last saw the deceased alive on Oct. 23, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death										
22b. SIGNATURE Don B. Cameron, M. D. 22c. ADDRESS 3503 Perry St., Mt. Rainier, Md. 20822										
22d. PHYSICIAN'S NAME (Type) Don B. Cameron, M. D.										
22e. ADDRESS 3503 Perry St., Mt. Rainier, Md. 20822										
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)	
Burial			Oct 26, 1968			Ft Lincoln Cemetery			Colmar Manor Pro Geo Md.	
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.										
25a. REC'D BY REGISTRAR DATE OCT 28 1968										
25b. REGISTRAR'S SIGNATURE Charles Judge										



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
304A REV 1/68

14818										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										14826																			
1 DECEASED NAME (Type or print)										First Middle Last										2a. DATE OF DEATH										2b. HOUR									
Irene										S. Bean										October 29 1968										7:30 A M									
3. SEX					4. RACE					5. DATE OF BIRTH					6. AGE (In years last birthday)					IF UNDER 1 YEAR					IF UNDER 24 HRS.														
Female					White					12-2-83					84 YRS.					MONTHS DAYS					HOURS MIN														
7a. BIRTHPLACE (State or foreign country)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH																								
Maryland					USA										Prince George Md																								
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY																			
Riverdale					Eugene Leland Memorial										Housewife																								
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER																			
Maryland					Prince Geo.					Beltsville										3107 Craiglawn Rd.																			
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME																																		
John Brady					Sarah Jones																																		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown					16b. SOCIAL SECURITY NO.					17. INFORMANT Address																													
No					none					Medical Records																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																								
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>GASTROINTESTINAL BLEEDING</u>															2 days																								
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Esophagus / Ulcers</u>															7 yr																								
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinosis Liver</u>															Many yr																								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																																							
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																													
21d. INJURY OCCURRED White <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																													
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct. 27</u> , 19 <u>68</u> , to <u>Oct. 29</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Oct. 29</u> , 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																							
22b. SIGNATURE <u>R. F. Wilkinson</u> DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>										22c. DATE SIGNED <u>Oct 29. 1968</u>																													
22d. PHYSICIAN'S NAME (Type) <u>R. F. Wilkinson, M.D.</u>										22e. ADDRESS <u>4408 Queensbury Rd., Riverdale, Md.</u>																													
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)																								
Burial					11.1.68					Epiphany Cemetery					Forestville Maryland																								
24. FUNERAL DIRECTOR ADDRESS										25a. REC'D BY REGISTRAR DATE										25b. REGISTRAR'S SIGNATURE																			
Lee Funeral Home 300.4th st N E Wash. D.C.										NOV 4 1968										Charles Judge																			

MEDICAL CERTIFICATION



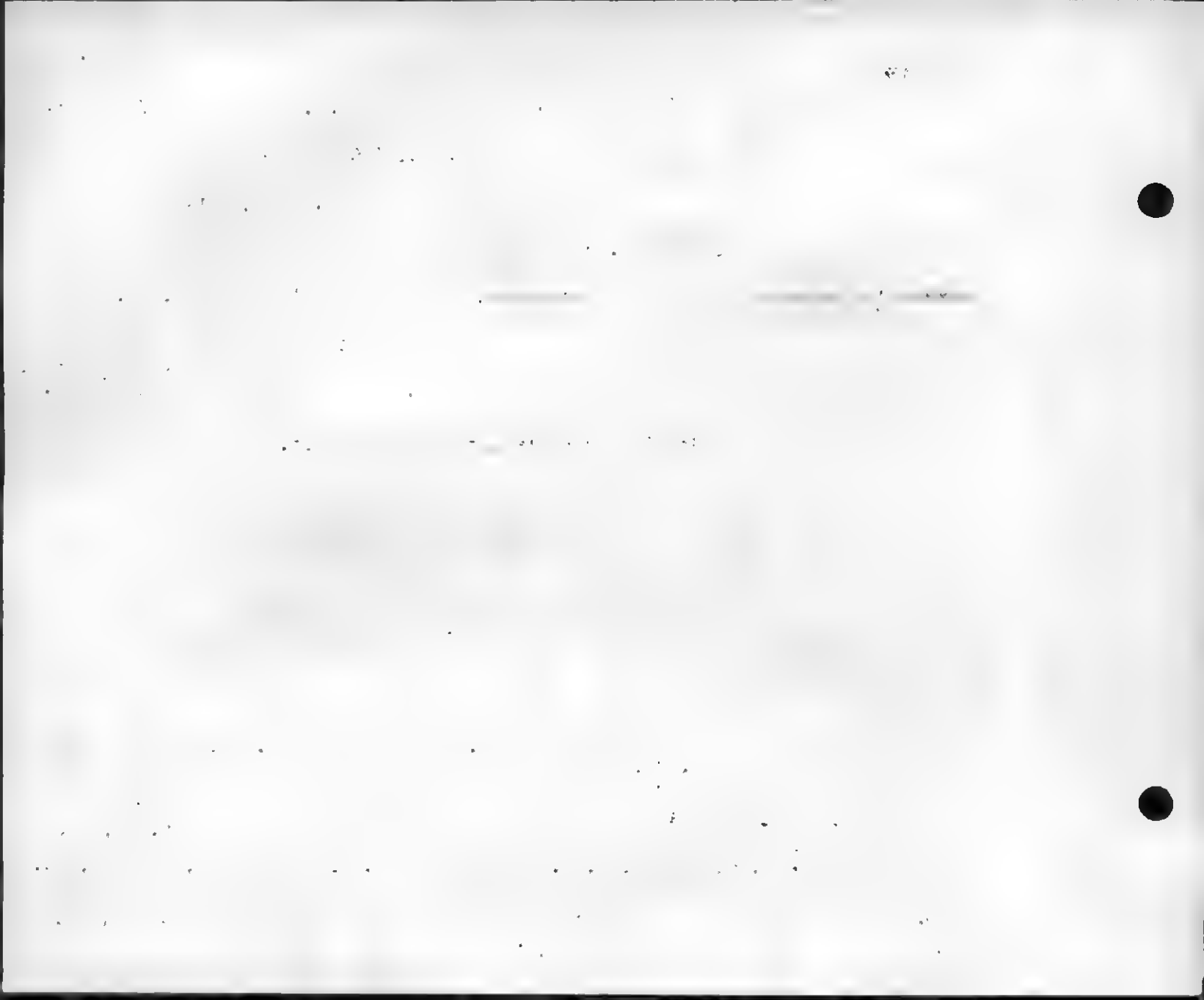
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
CERTIFICATE OF DEATH														
14819		14827												
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH			2b. HOUR P		
Maude			L.		Bender		Oct.			Month 28, Day 1968 Year		12:15 PM		
3 SEX		4 RACE		5. DATE OF BIRTH				6. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female		Caucasian		March 3, 1901				67 YRS.		MONTHS DAYS		HOURS MIN		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH							
Ohio			U S A				Prince George's					Md		
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Cheverly				Prince Geo. Gen'l Hospital				Housewife						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before death)				13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER						
MARYLAND Prince Geo.				Coral Hills		YES <input type="checkbox"/> NO <input type="checkbox"/>		5313 P Street, SE.						
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME			First Middle Last		
Payne					Stone				Evalina Richardson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.		17. INFORMANT			Address						
Yes, no, or unknown <input type="checkbox"/> (If yes give war or dates of service)					Raymond C. Bender			College Park, College Park, 9711 52nd Ave. Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a) <u>Massive acute left cerebral infarct.</u>														
DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
DUE TO, OR AS A CONSEQUENCE OF														
(c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes				
21a. ACCIDENT WAS UNDERLYING			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			HOUR A.M. Month Day Year P.M. 19											
21d. INJURY OCCURRED			21e. PLACE OF INJURY			21f. LOCATION								
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			(AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			Street or R.F.D. No. City or Town County State								
22a. I certify that <del>xx</del> (this hospital) attended the deceased from <u>Oct. 21, 1968</u> , to <u>Oct. 28, 1968</u> , that <del>xx</del> (we) lost saw the deceased alive on <u>Oct. 28, 1968</u> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above <del>xx</del> (we) (did) <del>not</del> view the body after death.														
22b. SIGNATURE						DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED				
<i>Tomas J. Hernandez</i>										Oct. 28, 1968				
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS								
Tomas J. Hernandez, M. D.						Prince Geo. Gen'l Hospital, Cheverly, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)							
Burial		11-1-68		Cedar Hill Cemetery			Suitland, Pr. Geo. Md.							
24. FUNERAL DIRECTOR						ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Wilhelm Funeral Home 4308 Suitland Rd. S. E.								DATE NOV 4 1968		<i>J. Charles Judge</i>				

MEDICAL CERTIFICATION

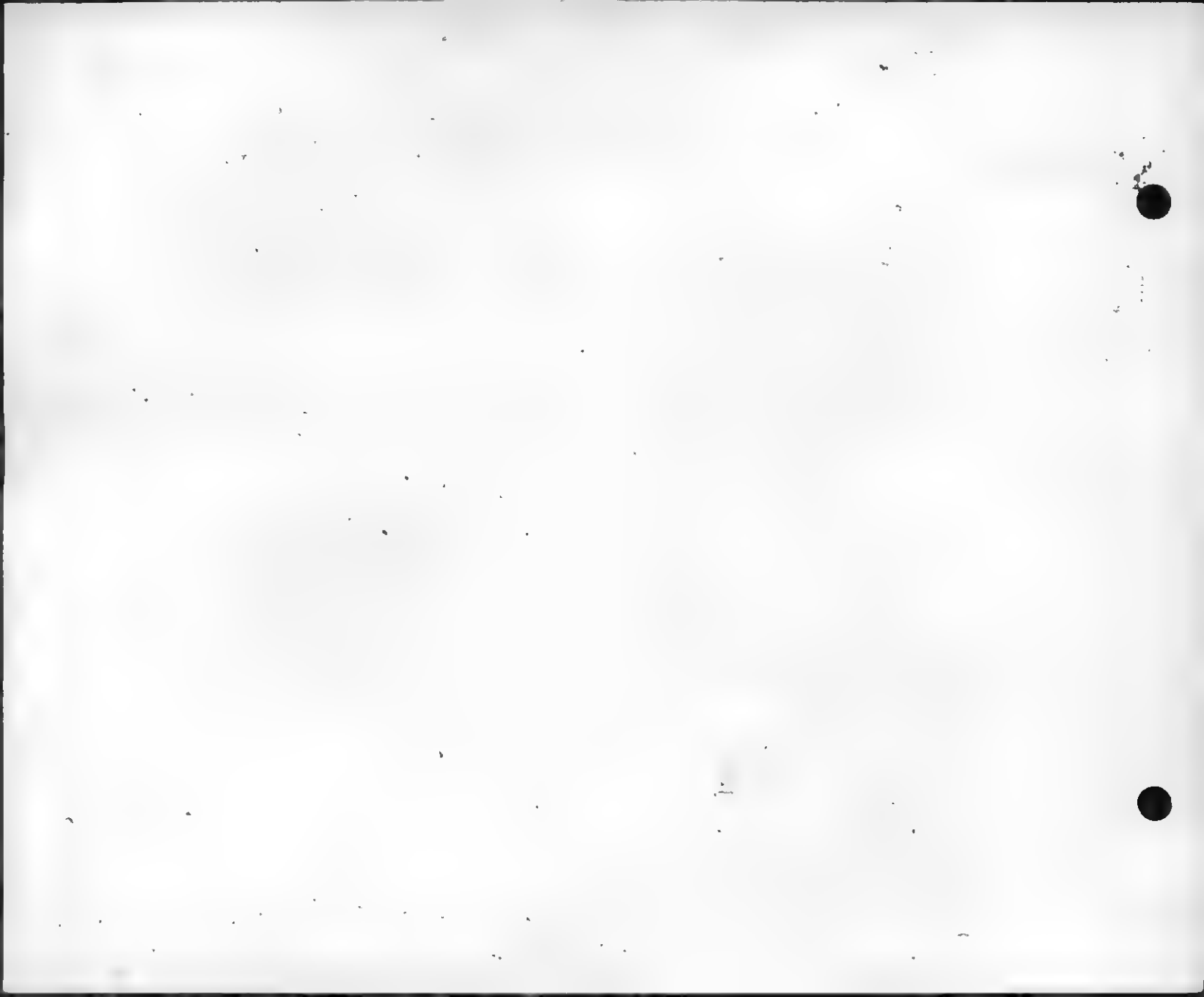




14820										14828														
1. DECEASED-NAME (Type or print) <b>Suzanne Bennett</b>										2a. DATE OF DEATH Month <b>Oct.</b> Day <b>5</b> Year <b>1968</b> 2b. HOUR <b>8:20<sup>AM</sup></b>														
3 SEX <b>Female</b>					4. RACE <b>Cav.</b>					5. DATE OF BIRTH <b>7-30-1880</b>					6. AGE (In years last birthday) <b>88</b> YRS.									
7a. BIRTHPLACE (State or foreign country) <b>Penna.</b>					7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH <b>Prince George</b> Md.									
10. CITY OR TOWN OF DEATH <b>Greenbelt</b>					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Greenbelt Convalescent Center</b>					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>housewife</b>					12b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>									
13a. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) STATE <b>md</b>					13b. COUNTY <b>Pr. Geo</b>					13c. CITY OR TOWN <b>Hyattsville</b>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
14. FATHER'S NAME First <b>Samuel</b> Middle <b>Hallman</b> Last <b>Hallman</b>					15. MOTHER'S MAIDEN NAME First <b>Loring</b> Middle <b>Loring</b> Last <b>Loring</b>																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b> (If yes give war or dates of service)					16b. SOCIAL SECURITY NO.					17. INFORMANT <b>Mrs. Paul B. Skind 311-Commander</b> Address <b>College Hgts.</b>														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>-437.9</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Fracture of R hip</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cerebral arteriosclerosis</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																								
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY <b>5:30 P.M. Aug 11, 1968</b>					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Fell out of bed</b>														
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>					21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Greenbelt Convalescent</b>					21f. LOCATION Street or R.F.D. No <b>7010 Greenbelt</b> City or Town <b>Greenbelt</b> County <b>PG</b> State <b>MD</b>														
22a. I certify that (I) (this hospital) attended the deceased from <b>Aug 11, 1968</b> , to <b>5 Oct 1968</b> , that (I) (we) last saw the deceased alive on <b>3 Oct 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. <b>Accident</b>																								
22b. SIGNATURE <b>Arthur Kaufman MD</b>										22c. DATE SIGNED <b>5 Oct 68</b>														
22d. PHYSICIAN'S NAME (Type) <b>ARTHUR KAUFMAN</b>										22e. ADDRESS														
23a. BURIAL-CREATION, REMOVAL (Specify) <b>Burial</b>					23b. DATE <b>Oct 8-1968</b>					23c. NAME OF CEMETERY OR CREMATORY <b>Greenbelt Memorial Home</b>					23d. LOCATION (City or Town) <b>Greenbelt</b> (County) <b>PG</b> (State) <b>MD</b>									
24. FUNERAL DIRECTOR <b>Arthur Walters</b>										25a. REC'D BY REGISTRAR <b>Charles Judge</b>										25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				
										DATE <b>OCT 8 1968</b>														

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and return them to the funeral director. This certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



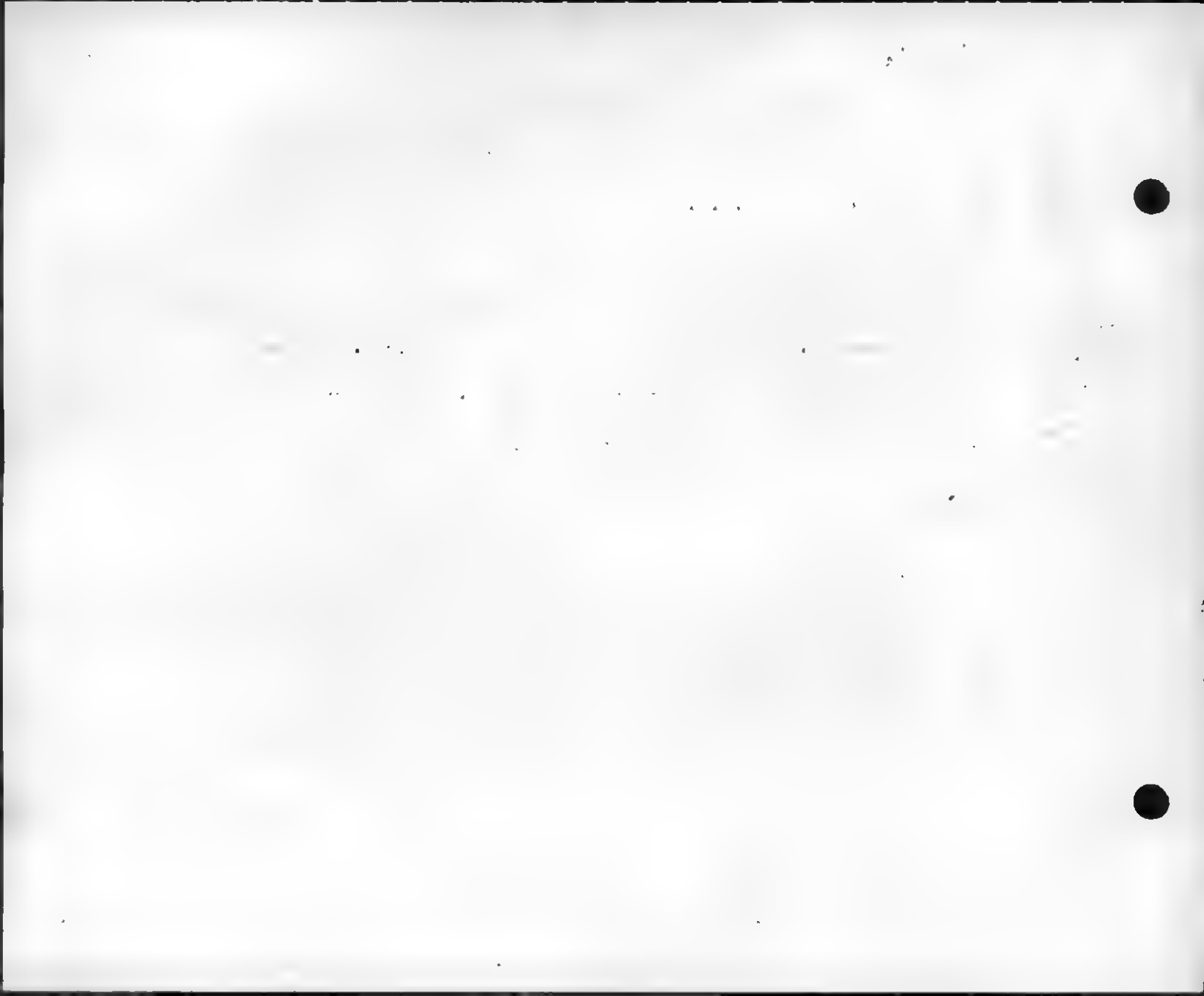
4  
4  
15  
14821  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
14829

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
Arthur		E	Bingler	Month Oct. 18 Day 18 Year 1968		10:30		
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		7. IF UNDER 1 YEAR MONTHS DAYS	
Male	Caucasian		4/12/08		60 YRS.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Virginia		U.S.A.				Prince George's Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly		Prince George's General		Bus Driver		Public School		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland		Prince Geo.		Seat Pleasant				309 70th St.
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle Last
James E. Bingler					Annie K. Hughson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, name (unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
Yes		WWII		577-30-6283		Anna R. Ridgeway - Same as # 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>								
4109 DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4201</u> (b) <u>Arteriosclerotic Cardiovascular Disease</u>								
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
<u>Renal Shutdown &amp; Anemia, persistent shock.</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from <u>10/18</u> , 19 <u>68</u> , to <u>18 Oct</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>17 Oct</u> , 19 <u>68</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED
<u>[Signature]</u>								<u>18 Oct. 1968</u>
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS				
R Deitz				Pro Geo Plaza, Hyattsville, Md.				
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		Oct 21, 1968		Ft Lincoln Cemetery		Colmar Manor Pro Geo Md.		
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
F. Gasch's Sons				Hyattsville, Md.		DATE OCT 22 1968 <u>[Signature]</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

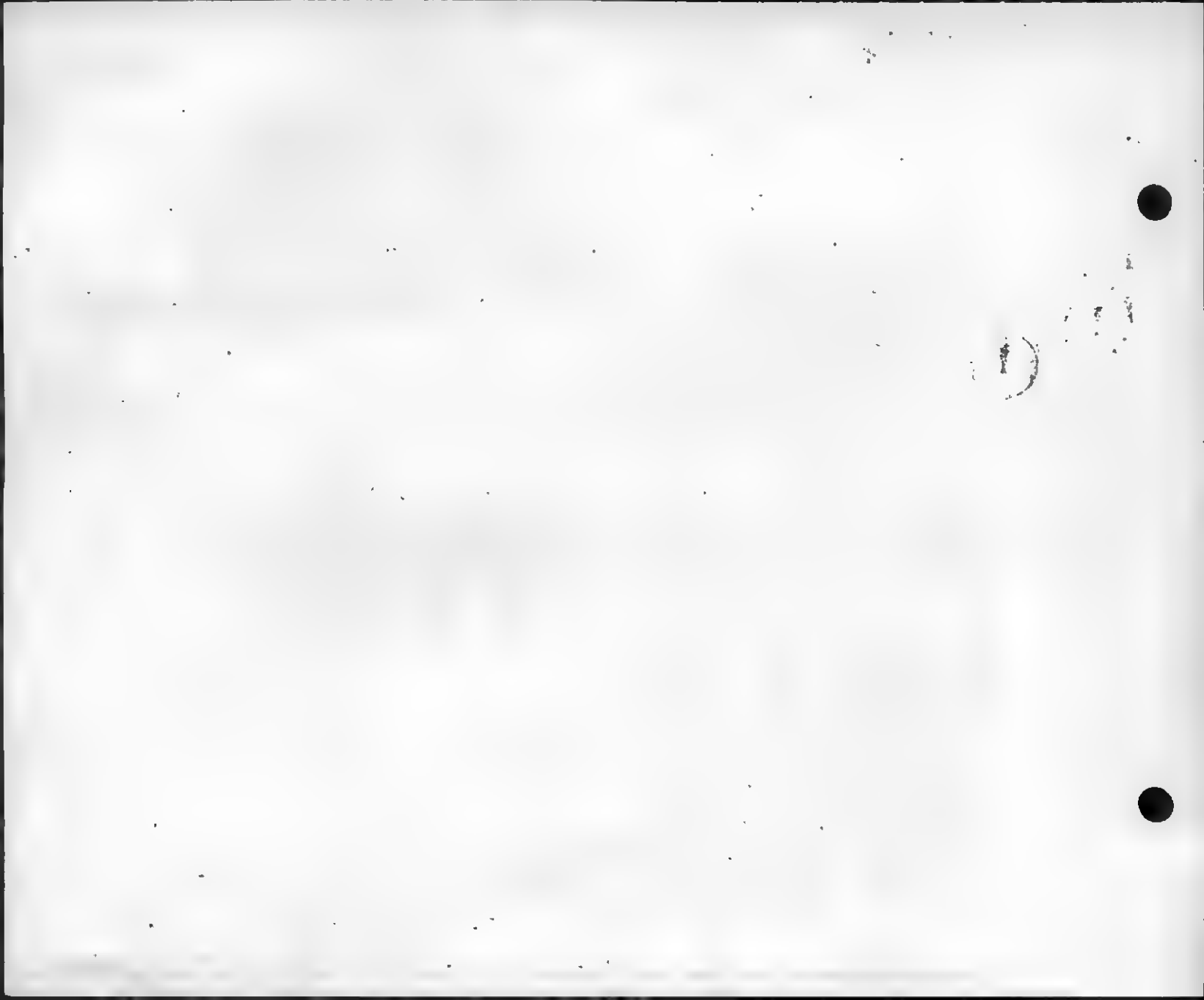


CERTIFICATE OF DEATH

14830

1 DECEASED-NAME (Type or print) <b>Richard</b>		First <b>L.</b>	Middle <b>owman</b>	2a. DATE OF DEATH Month <b>10</b> Day <b>11</b> Year <b>68</b>	2b. HOUR <b>12 05 PM</b>
3 SEX <b>Male</b>	4 RACE <b>White</b>	5 DATE OF BIRTH <b>August 13 1976</b>		6 AGE (In years lost birthday) <b>12</b> YRS.	IF UNDER YEAR MONTHS <b>12</b> DAYS <b>12</b> HOURS <b>12</b> MIN
7a BIRTHPLACE (State or foreign country) <b>Ohio</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Prince George's</b> Md		
10. CITY OR TOWN OF DEATH <b>Yattsville</b>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Carroll Manor</b>	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>General</b>	12b KIND OF BUSINESS OR INDUSTRY <b>IS out</b>		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>D.C.</b> CITY OR TOWN <b>Washington</b> INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13b STREET AND NUMBER <b>2701 Conn. Ave.</b>				
14. FATHER'S NAME First <b>Richard</b> Middle <b>Bowman</b> Last <b>Ann</b>	15. MOTHER'S MAIDEN NAME First <b>Ann</b> Middle <b>E.</b> Last <b>Brennan</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or unknown <b>None</b> (If yes give year or dates of service)	16b SOCIAL SECURITY NO. <b>570 60 3355</b>	17 INFORMANT Address <b>Richard Timmons Washington, D.C.</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> <b>4127</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>4 years</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4</b>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>5/17</b> , 19 <b>67</b> , to <b>10/11</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>Oct. 10</b> , 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Thomas F Collins</b>	DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c DATE SIGNED <b>10/11/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>THOMAS F COLLINS</b>	22e. ADDRESS <b>355 - H ST NE</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Interment</b>	23b. DATE <b>10/15/1968</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Greenwood Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Washington D.C.</b>		
24 FUNERAL DIRECTOR <b>alley's Funeral Home</b>	ADDRESS <b>It. Rainier, Md.</b>	25a REC'D BY REGISTRAR DATE <b>OCT 15 1968</b>	25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be received within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1514  
30M REV 1/68

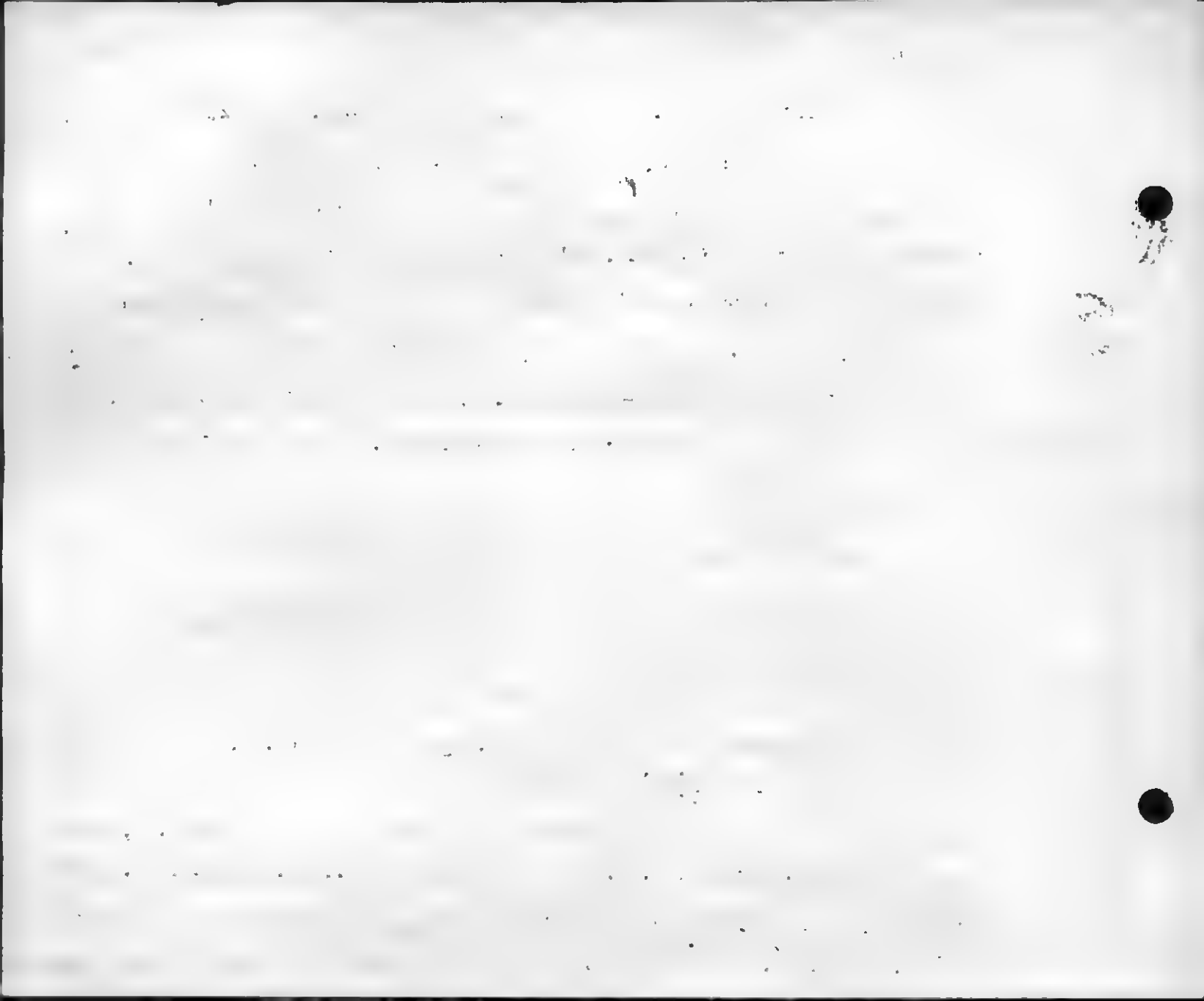
14829

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14831

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR DOA	
Glen R. Brant						Oct.	Month	Day	Year	6:15p
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS.
Male		Caucasian		August 27, 1928		40 YRS		MONTHS		DAYS
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY		
Maryland		U S A				Prince George's		Jr. High		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly DOA			Prince Geo. Gen'l Hospital			School Teacher			Jr. High	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Maryland			Prince George's		Laurel		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13307 Edinburg Lane	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO	
First Middle Last Ralph R. Brant			First Middle Last Hazel Moreland			Yes No Yes			216-22-6038	
17. INFORMANT			Address			17. INFORMANT			Address	
Mrs. Martha Brant			13307 Edinburg Lane			Mrs. Martha Brant			13307 Edinburg Lane	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction.</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF (a) _____ (b) _____ (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) <del>XXXXXX</del> attended the deceased from <u>Oct. 2, 1968</u> , to <u>Oct. 2, 1968</u> , that <del>we</del> (we) last saw the deceased alive on <u>Oct. 2, 1968</u> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>we</del> (did) <del>not</del> view the body after death.										
22b. SIGNATURE						22c. DATE SIGNED				
<u>Don B. Cameron</u>						Oct. 3, 1968				
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS				
Don B. Cameron, M. D.						3503 Perry St., Mt. Rainier, Md. 20822				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			10/5/1968		Sunset Memorial Park			Near Cumbe land Alleg Md		
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE	
John J. Hafer, Jr.						OCT 7 1968			Charles Judge	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

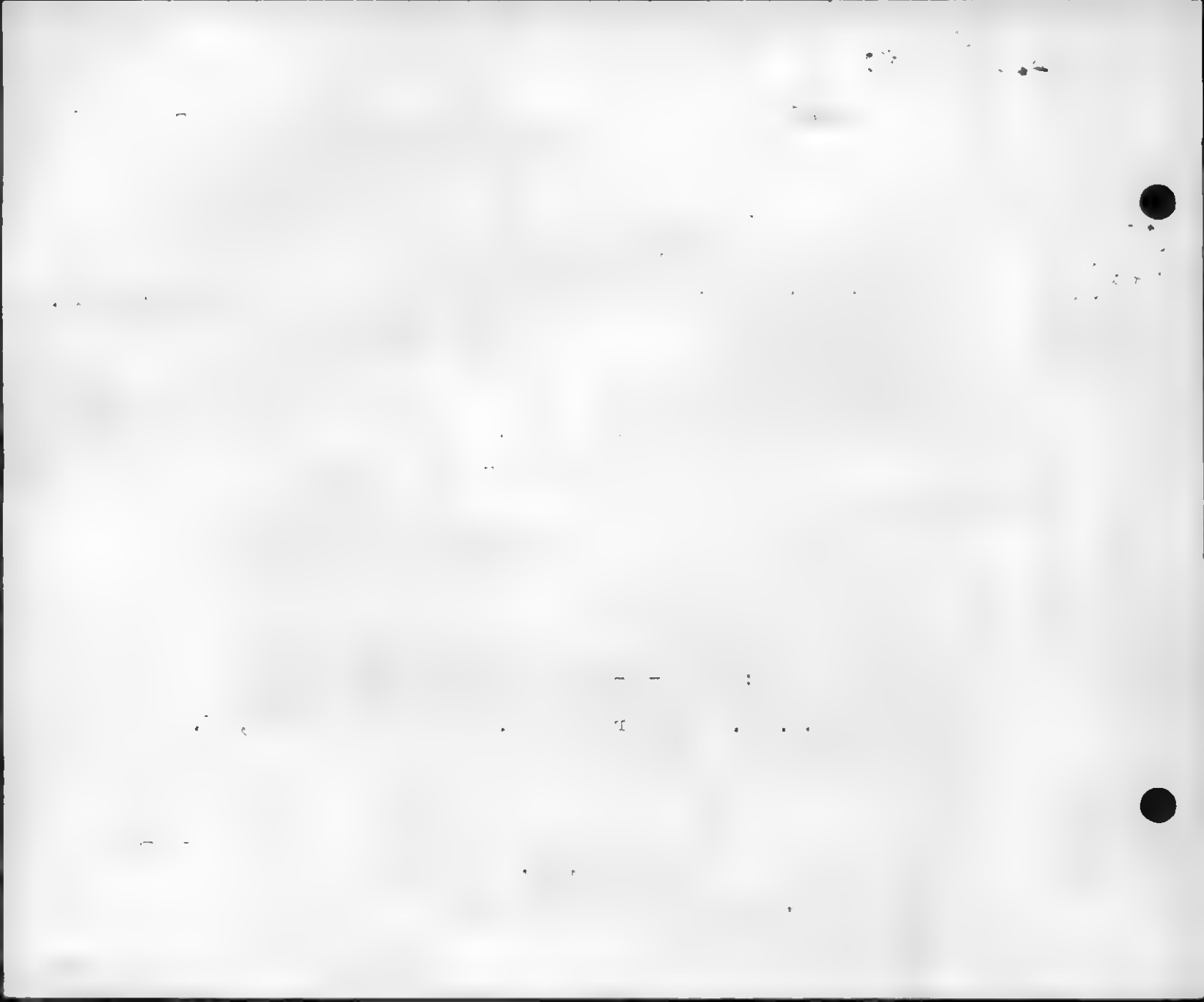
Item 8 Film 66-117/68 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14824

14832

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month Day Year			2b. HOUR					
Ethel			Braxton			10-28-68			19			25am					
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 UNDER 24 HRS	8 MONTHS	9 DAYS	10 HOURS	11 MIN	2c. DATE PRONOUNCED DEAD			2d. HOUR					
Female	Negro	3-11-37	31 YRS						10-28-68			19 25am					
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md					
D. C.			U.S.A.						Prince George's								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY								
Cheverly			Prince George Hospital														
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER					
District of Columbia			Washington						YES <input type="checkbox"/> NO <input type="checkbox"/>			2313 Douglas Street N.E.					
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME														
William Tolliver			Geneva Smith														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS								
No			None														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Laceration of brain																	
14. 7 DUE TO, OR AS A CONSEQUENCE OF Trauma - struck by car																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																	
(b) DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
1124																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?								
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
			11:44pm 10-12-19 68			Pedestrian struck by car											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town			County		State			
			U.S. Rt. 1 at Muirkirk Road						Prince George County			Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED		
John Kehoe MD			Riverdale, Md.												10-28-68		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town)			(County)			(State)		
Burial			10-1-68			Queens Chapel Methodist Ch. Cemetery			Muirkirk, Maryland								
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR						25b. REGISTRAR'S SIGNATURE					
John T. Rhines Company Funeral Home						NOV 1 1968						Charles Judge					
3015 12th Street, N. E.																	

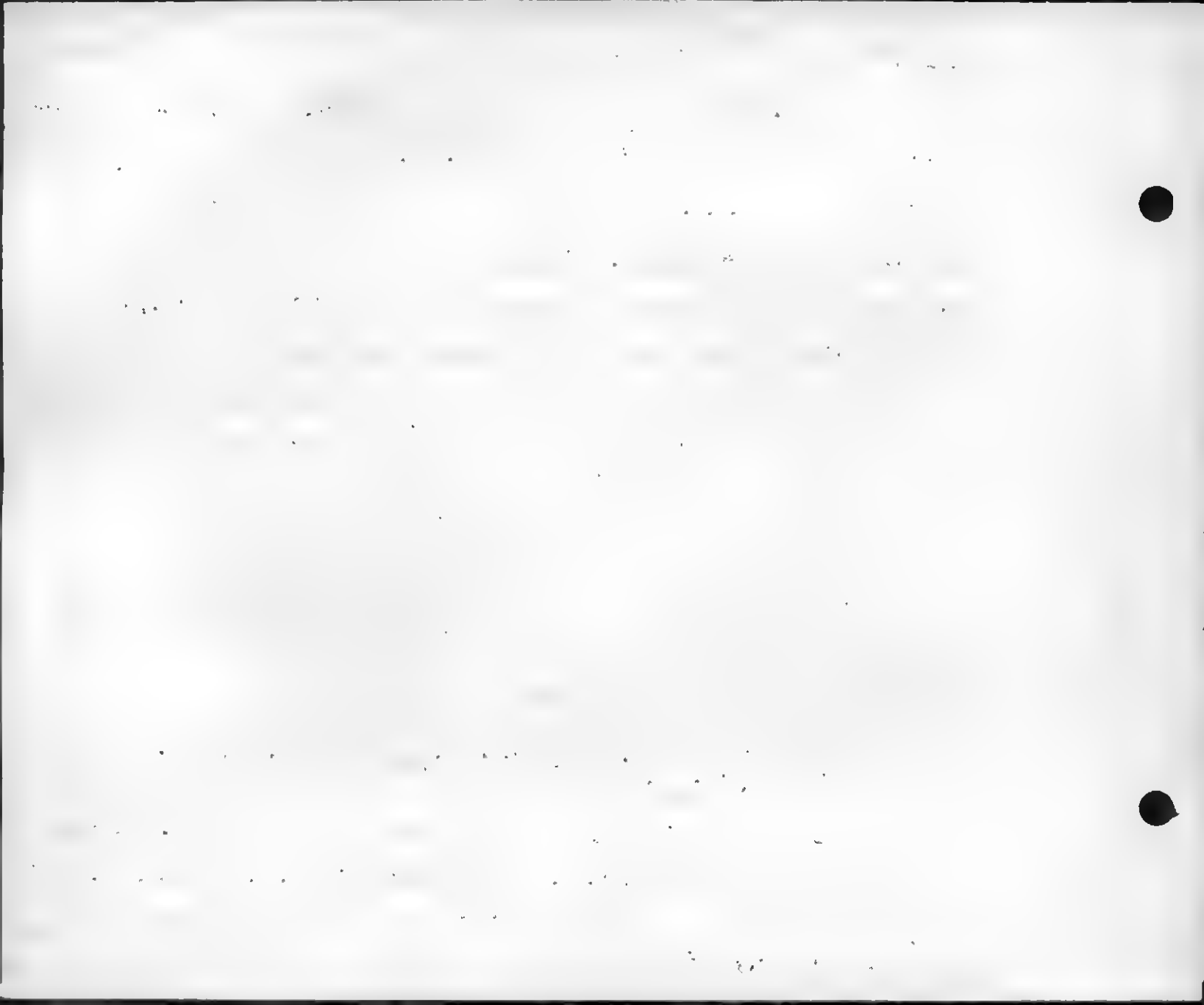


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 4 and 5) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 7-58

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)		First		Middle		Last		2a DATE OF DEATH Month Day Year		2b HOUR A	
Baby		Boy		Bristol		Oct.		Month 24, Day 1968 Year		10:45M	
3 SEX Male		4 RACE Caucasian		5. DATE OF BIRTH Oct. 22, 1968		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.					
10. CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen'l Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Prince George's		13c. CITY OR TOWN Landover		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 7210 Forest Rd., #2			
14. FATHER'S NAME First Middle Last William Earl Bristol		15. MOTHER'S MAIDEN NAME First Middle Last Barbara Nell Collins									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture of skull, it is subdural &amp; epidural</u> DUE TO, OR AS A CONSEQUENCE OF <u>hemorrhage</u> (b) <u>Tortorial tear bilateral with hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF <u>in posterior face.</u> (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>7200</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) <u>did not</u> attend the deceased from <u>Oct. 22, 1968</u> , to <u>Oct. 24, 1968</u> , that (I) <u>xxx</u> last saw the deceased alive on <u>Oct. 22, 1968</u> , and that in (my) <u>xxx</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>xxx</u> (did) (did not) view the body after death.											
22b. SIGNATURE <u>Bernardo Alvarado, M. D.</u>		22c. DATE SIGNED Oct. 24, 1968		22d. PHYSICIAN'S NAME (Type) Bernardo Alvarado, M. D.		22e. ADDRESS 6201 Riverdale Rd., Riverdale, Md. 20840					
23a. BURIAL CREMATION REMOVAL (Specify)		23b. DATE 11-2-68		23c. NAME OF CEMETERY OR CREMATORY Prince George's General		23d. LOCATION (City or Town) (County) (State) Cheverly, Maryland					
24. FUNERAL DIRECTOR <u>Henry W. Penn, Jr. Administrator</u>		ADDRESS Hospital		25a. REC'D BY REGISTRAR DATE NOV 6 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					



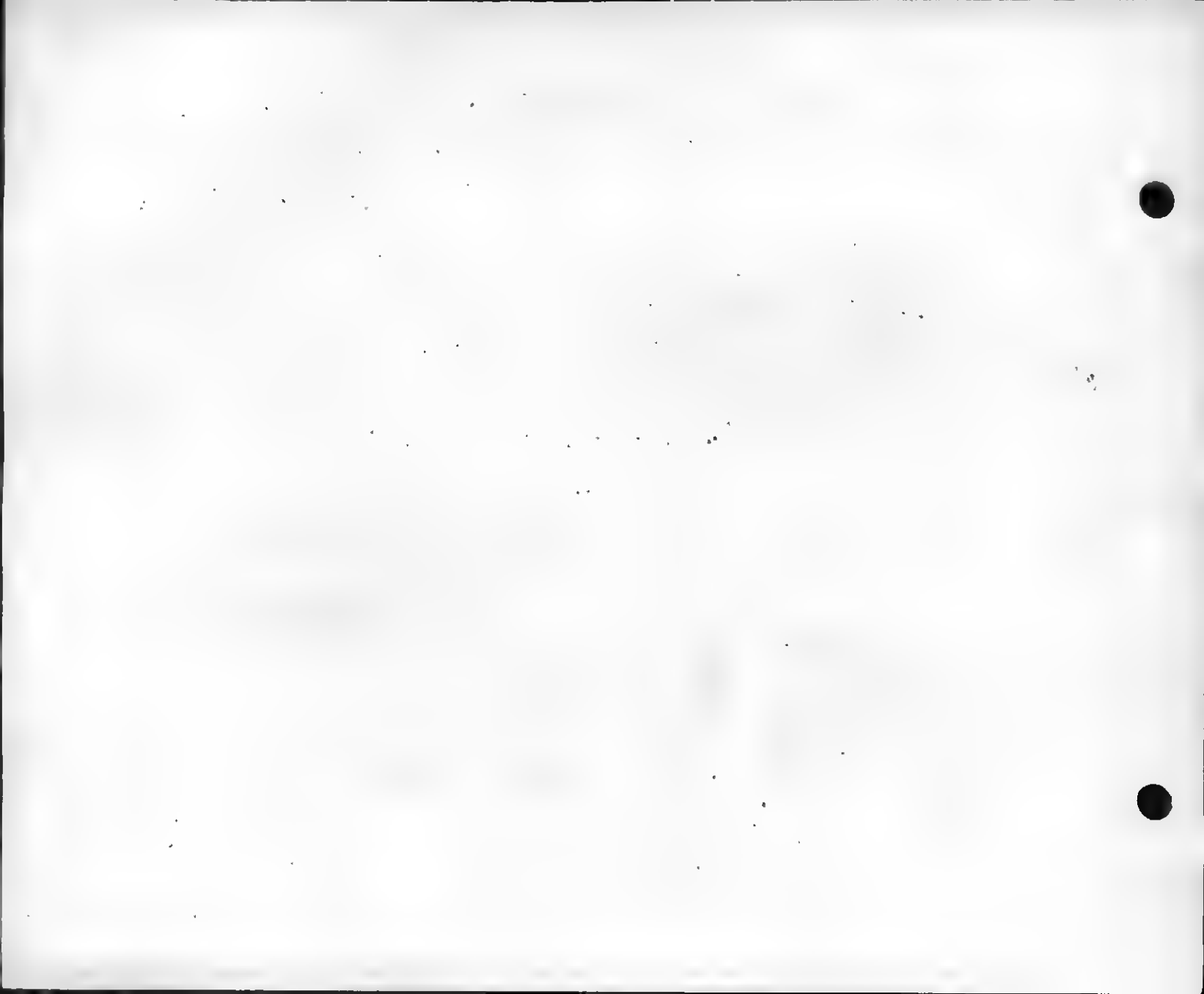


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VR A15  
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
14826 CERTIFICATE OF DEATH 14834													
1. DECEASED NAME (Type or print) <b>G-RACE JANET BROSNIHAN</b>						2a. DATE OF DEATH <b>October 4, 1968</b>			2b. HOUR <b>7:15 A.M.</b>				
3. SEX <b>F</b>		4. RACE <b>W.</b>		5. DATE OF BIRTH <b>Dec. 2, 1921</b>			6. AGE (In years last birthday) <b>46</b> YRS		IF UNDER 1 YEAR MONTHS <b>4</b> DAYS <b>14</b> HOURS <b>15</b> MIN		IF UNDER 24 HRS HOURS <b>15</b> MIN		
7a. BIRTHPLACE (State or foreign country) <b>MASS.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>PRINCE GEORGE</b> Md.							
10. CITY OR TOWN OF DEATH <b>COLLEGE PARK</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>5703 VASSAR DR</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>				
13a. USUAL RESIDENCE (Where deceased lived, if institution) STATE <b>Md.</b>			13b. COUNTY <b>PRINCE GEORGE</b>			13c. CITY OR TOWN <b>COLLEGE PARK</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>5703 VASSAR DR.</b>	
14. FATHER'S NAME First <b>JOSEPH</b> Middle <b>PRUNIER</b> Last <b>PRUNIER</b>				15. MOTHER'S MAIDEN NAME First <b>ROSE</b> Middle <b>HARPER</b> Last <b>HARPER</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)				16b. SOCIAL SECURITY NO		17. INFORMANT <b>FRANCIS J. BROSNIHAN - Husband - ABOVE</b>			Address <b>SAME AS ABOVE</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))													
PART I. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <b>Generalized Carcinomatosis</b>													
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma of appendix</b>													
DUE TO, OR AS A CONSEQUENCE OF (c) <b>2 yrs.</b>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
<b>1550</b>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. <b>19</b> Month <b>10</b> Day <b>4</b> Year <b>1968</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. <b>2513 Buck Lodge Rd.</b> City or Town <b>Adelphi</b> County <b>P.R.</b> State <b>Md.</b>							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>9-27-68</b> , 19 <b>68</b> , to <b>10-4-68</b> , 19 <b>68</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>10-2-68</b> , 19 <b>68</b> , and that in <input checked="" type="checkbox"/> (my) <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) <input checked="" type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death.													
22b. SIGNATURE <b>R.P. Bauer M.D.</b>						DEGREE <b>M.D.</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>10-4-68</b>				
22d. PHYSICIAN'S NAME (Type) <b>R.P. Bauer M.D.</b>						22e. ADDRESS <b>2513 Buck Lodge Rd. Adelphi Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>10/7/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN</b>			23d. LOCATION (City or Town) <b>SILVER SPRINGS</b> (County) <b>P.R.</b> (State) <b>Md.</b>					
24. FUNERAL DIRECTOR <b>F. GASCH'S SONS - Hyattsville, Md.</b>						ADDRESS <b>Hyattsville, Md.</b>			25a. REC'D BY REGISTRAR <b>DATE OCT 8 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Johnas Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15  
3044 REV 11-67

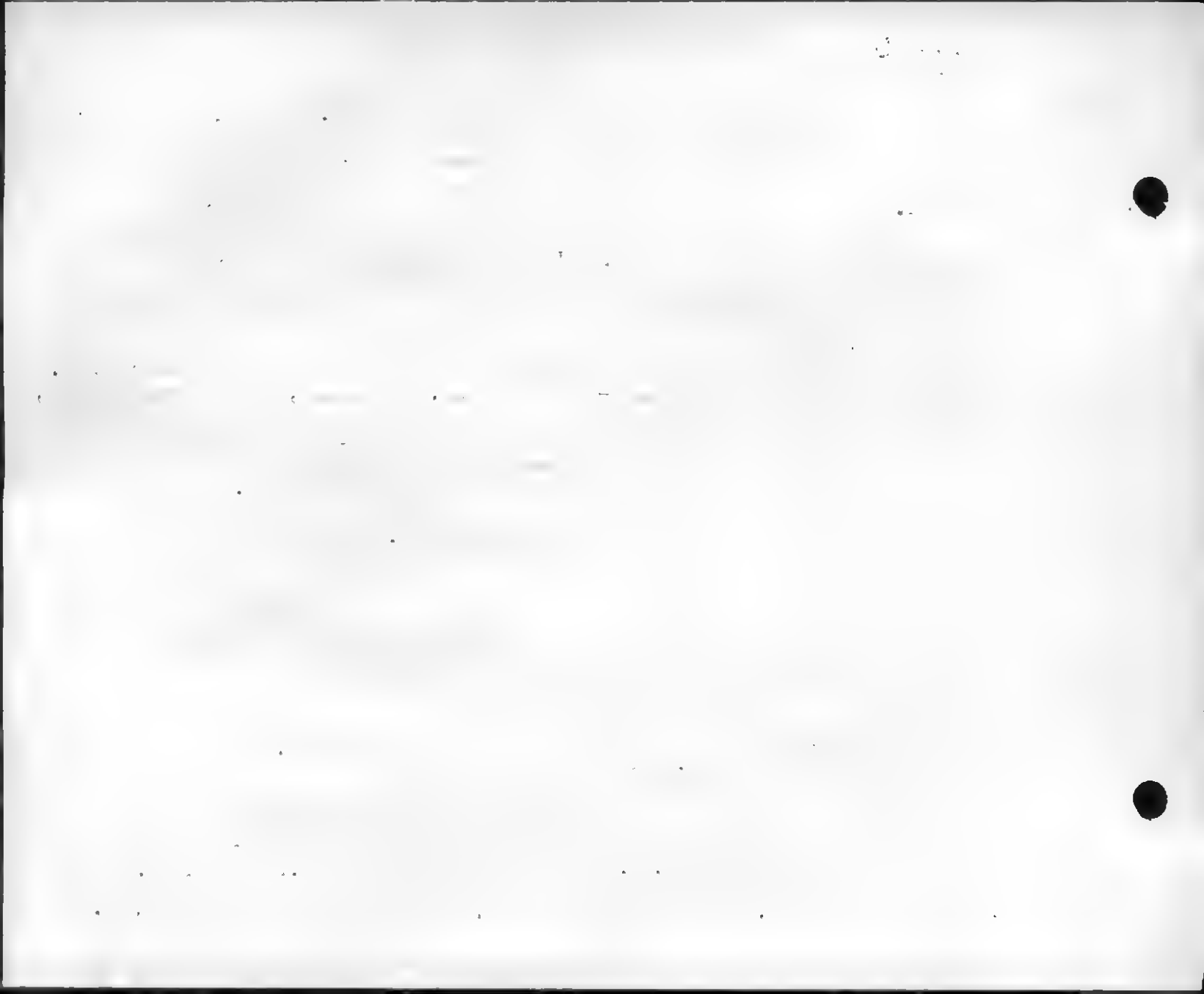
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 13 Film 406 114 68 41

14827

14836

CERTIFICATE OF DEATH

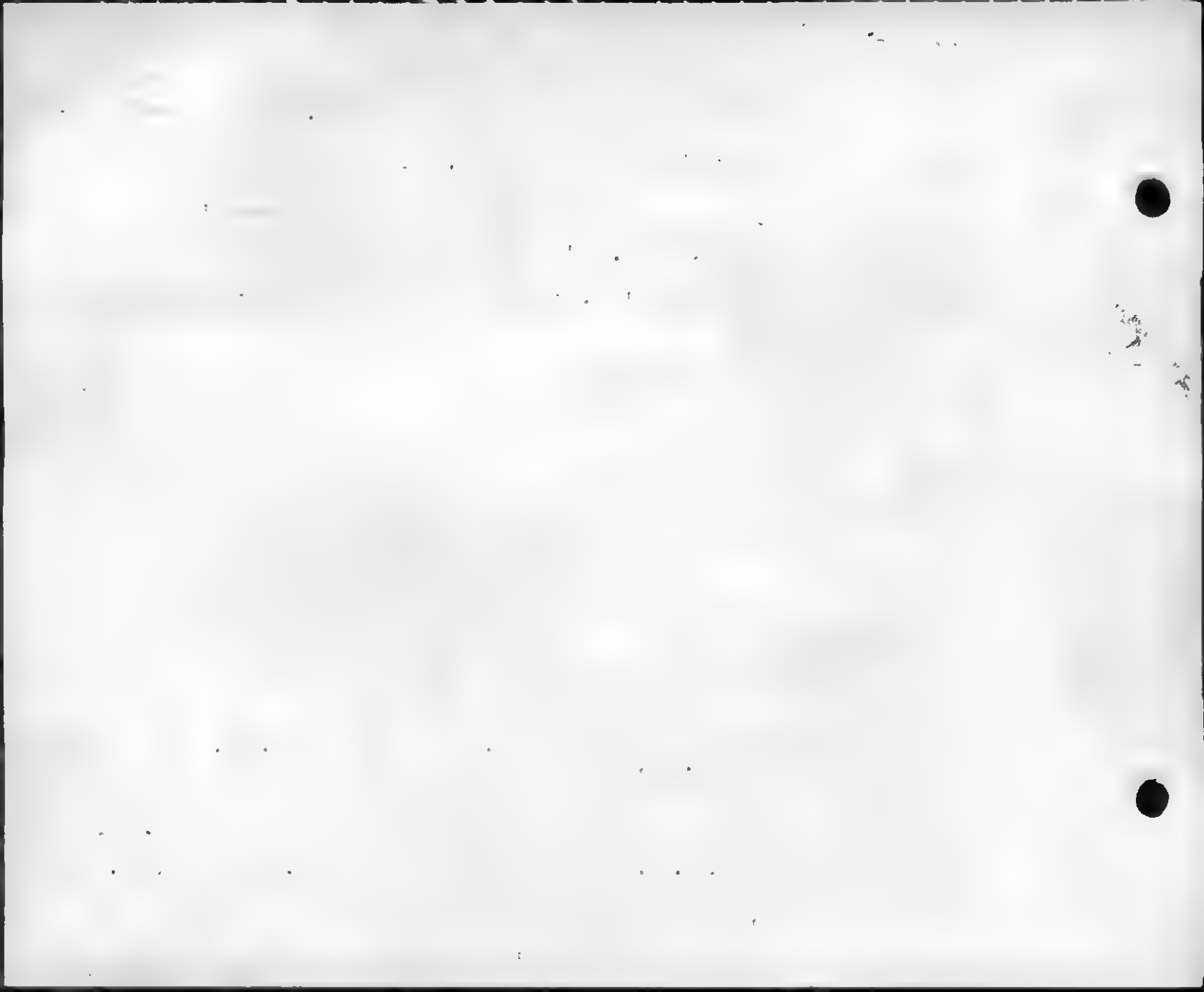
1. DECEASED NAME (Type or print) <b>George E Brumfield</b>			2a. DATE OF DEATH Month <b>Oct.</b> Day <b>20</b> Year <b>1968</b>			2b. HOUR <b>9:30</b> P <b>M</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Feb. 2, 1904</b>		6. AGE (In years last birthday) <b>64</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Penn.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George's</b> Md	
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo. Gen'l Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>School Teacher</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Charles County</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Charles</b>		13c. CITY OR TOWN <b>LaPlata</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>Woodcrest Apts.,</b>		13f. CITY OR TOWN <b>Regency Nursing Home</b>		13g. STREET AND NUMBER <b>Regency Nursing Home</b>		13h. CITY OR TOWN <b>LaPlata</b>	
14. FATHER'S NAME First Middle Last <b>Howard Brumfield</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Laura Rugg</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <b>No</b>	
16b. SOCIAL SECURITY NO <b>206-07-6346A</b>			17. INFORMANT Address <b>Wm. F. Brumfield, 952 Nichols Drive, Laurel, Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bronchogenic carcinoma - right - with metastasis</b> DUE TO, OR AS A CONSEQUENCE OF <b>to mediastinal lymph node - hilar lymph nodes - lungs and liver.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Bilateral Broncho-pneumonia.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Bilateral Broncho-pneumonia.</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>1621</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (1) <del>this hospital</del> attended the deceased from <b>7-5-</b> , 19 <b>64</b> , to <b>Oct. 20</b> , 19 <b>68</b> , that (1) <del>he</del> saw the deceased alive on <b>Oct. 20</b> , 19 <b>68</b> , and that in (my) <del>his</del> opinion death occurred on the date and hour and from the causes stated above, (1) <del>he</del> (did) <del>not</del> view the body after death.							
22b. SIGNATURE <b>Oliver Bond, M. D.</b>		22c. ADDRESS <b>6872 Riverdale Rd., Lanham, Md. 20801</b>		22d. PHYSICIAN'S NAME (Type) <b>Oliver Bond, M. D.</b>		22e. ADDRESS <b>6872 Riverdale Rd., Lanham, Md. 20801</b>	
22f. DATE SIGNED <b>10-21-68</b>		22g. DATE SIGNED <b>10-21-68</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>Oct. 24, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Trinity Mem. Gardens</b>		23d. LOCATION (City or Town) (County) (State) <b>Waldorf, Charles, Md.</b>	
24. FUNERAL DIRECTOR <b>ABERHART FUNERAL HOME INC</b>		ADDRESS <b>LA PLATA, MD</b>		25a. REC'D BY REGISTRAR <b>OCT 25 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <span>14828</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>14837</span> </div>													
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH Month <u>Oct.</u> Day <u>28</u> Year <u>1968</u>			2b. HOUR <u>4:30</u> <sup>A</sup> <sub>M</sub>	
3. SEX <b>Male</b>			4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>Jan. 18, 1912</b>			6. AGE (In years last birthday) <b>56</b> YRS		IF UNDER 1 YEAR MONTHS <u>    </u> DAYS <u>    </u>		IF UNDER 24 HRS HOURS <u>    </u> MIN <u>    </u>	
7a. BIRTHPLACE (State or foreign country) <b>Va</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Prince George's</b>			10. CITY OR TOWN OF DEATH <b>Cheverly</b>		
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Geo. Gen'l Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Welder</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>steel</b>			13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b> COUNTY <b>Prince George's</b>				
13b. CITY OR TOWN <b>Riverdale</b>			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13d. STREET AND NUMBER <b>5816 Quintanna Street</b>			14. FATHER'S NAME First <b>John</b> Middle <b>Burnley</b> Last <b>Asby</b>				
15. MOTHER'S MAIDEN NAME First <b>Asby</b> Middle <b>Cash</b> Last <b>Cash</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>    </u> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>231 07 6087</b>			17. INFORMANT <b>Margaret C Burnley</b> Address <b>E Riverdale, Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Heart Failure.</u> DUE TO, OR AS A CONSEQUENCE OF <u>Cor Pulmonale</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>    </u> DUE TO, OR AS A CONSEQUENCE OF <u>Metastatic Carcinoma</u> (c) <u>    </u>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 hr</u> <u>with</u> <u>2 yrs</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. <u>    </u> Month <u>    </u> Day <u>    </u> Year <u>19</u> P.M. <u>    </u>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No <u>    </u> City or Town <u>    </u> County <u>    </u> State <u>    </u>						
22a. I certify that (I) <del>(the hospital)</del> attended the deceased from <u>Dec.</u> , 19 <u>65</u> , to <u>Oct. 28</u> , 19 <u>68</u> , that (I) <del>(we)</del> lost saw the deceased alive on <u>Oct. 28</u> , 19 <u>68</u> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) <del>(not)</del> view the body after death.													
22b. SIGNATURE <u>John Kehoe, M. D.</u>								DEGREE <u>    </u> ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>Oct. 28, 1968</b>			
22d. PHYSICIAN'S NAME (Type) <b>John Kehoe, M. D.</b>								22e. ADDRESS <b>6300 Riverdale Rd. Riverdale, Md.</b>					
23a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>Oct 31, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Burnley Family Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Shipman Nelson Va</b>					
24. FUNERAL DIRECTOR <b>F. Masch's Sons</b>								ADDRESS <b>Hyattsville, Md</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 31 1968</b>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



*Confessed John A. Brown*

**INFORMING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death by the hospital or attending physician.

After this certificate has been signed by the attending physician and completely filled in by the informant, it must be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 of this certificate Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15 (4)  
EV-1468

<div style="display: flex; justify-content: space-between;"> <span>14829</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH</span> <span>14838</span> </div> <div style="text-align: center;">             DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  <b>CERTIFICATE OF DEATH</b> </div>									
1. DECEASED-NAME (Type or print) First Middle Last <b>John L. Capps</b>				2a. DATE OF DEATH Month/Day/Year <b>10/6/1968</b>				2b. HOUR M <b>AM</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>August 12 1913</b>		6. AGE (In years last birthday) <b>55</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>M.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George's</b> Md			
10. CITY OR TOWN OF DEATH <b>Heverly</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince George's</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Prince George's</b>		13c. CITY OR TOWN <b>College</b>		13d. INSIDE CITY LIM TS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>5028 Pa'uch Rd.</b>	
14. FATHER'S NAME First Middle Last <b>John T. Capps</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Jennie House</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>578 00 1837</b>		17. INFORMANT Address <b>Lleanor Capps Same as above</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>causes of coronary em</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>62</u> , to _____, 19____, that (I) (we) last saw the deceased alive on <u>10/2/68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>William Bergemann</u>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>10/7/68 4P</b>			
22d. PHYSICIAN'S NAME (Type) <b>William Bergemann</b>		22e. ADDRESS <b>Greenbelt, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10/9/1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Port Lincoln Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor, Maryland</b>			
24. FUNERAL DIRECTOR <b>Funeral Home Mt. Rainier, Md.</b>		ADDRESS		25a. REC'D BY REGISTRAR DATE <b>OCT 10 1968</b>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18&22a Film 406 MARYLAND STATE DEPARTMENT OF HEALTH  
11-13-68 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14830

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14839

1 DECEASED-NAME (Type or Print) First Middle Last <b>Daniel Timothy Carroll</b>			2a. DATE KNOWN OF DEATH Month Day Year <b>10-10-68</b>		2b. HOUR Minute <b>4:50am</b>
3 SEX <b>Male</b>	4. RACE <b>Negro</b>	5. DATE OF BIRTH <b>5-25-1968</b>	6. AGE (in years last birthday) YRS MONTHS DAYS <b>4 15</b>	2c. DATE PRONOUNCED DEAD Month Day Year <b>10 10 68</b>	
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George's</b>
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince George General Hosp.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>None</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Prince George's</b>	13c. CITY OR TOWN <b>Glenn Arden</b>	13d. INS DE CITY, JAN 15? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>8621 Leslie Avenue</b>
14. FATHER'S NAME First Middle Last <b>James Lyles</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Dorothy Ramsey</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) <b>NO</b>	
16b. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT <b>Dorothy R. Carroll</b>		ADDRESS <b>SAME AS 13E</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Undetermined</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>SDII</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>SDII</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day Year HOUR A.M. P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>John Kehoe</b>		EXAMINER'S NAME (Type) <b>John Kehoe MD</b>		22b. DATE SIGNED <b>10-11-68</b>	
23a. PLACE OF REMOVAL (Specify)		23b. DATE <b>10-14-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Albans Cem.</b>	
24. FUNERAL DIRECTOR <b>H.S. Washington &amp; Sons</b>		ADDRESS <b>4925 Deane Ave N.E.</b>		25a. REC'D BY REGISTRAR <b>OCT 17 1968</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. LOCATION (City or Town) (County) (State) <b>Washington DC</b>			



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

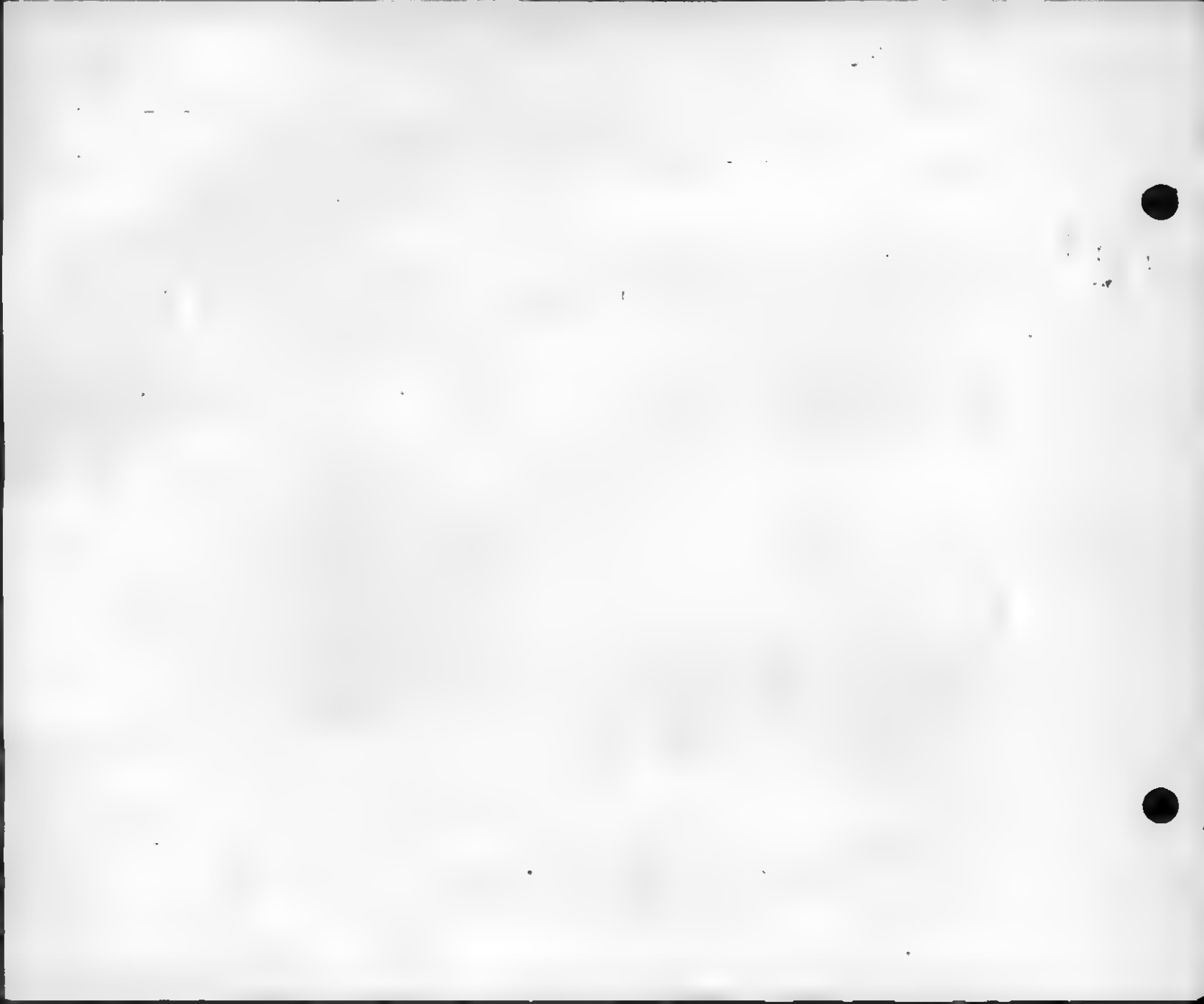
Items 18&22a Film 407 MARYLAND STATE DEPARTMENT OF HEALTH  
12-2-68 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14831

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14840

1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 10-28-68 195:50 PM				2b HOUR	
Meta Louise Casey											
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c DATE PRONOUNCED DEAD Month Day Year		2d HOUR	
Female	White	5-21-1924	44 YRS					10 28 68		6:00 PM	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			12b KIND OF BUSINESS OR INDUSTRY		
New York		U S A				Prince George's Md			Own home		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George Hospital			Housewife					
13a USUAL RESIDENCE (Where deceased lived, if not tuition Residence before admission)			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER		
Maryland			Prince George's		Bowie		YES <input type="checkbox"/> NO <input type="checkbox"/>		2505 Knight Hill Lane		
14. FATHER'S NAME			15 MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
John R Eimann			Helen McNamee								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO (If yes give war or dates of service)		17. INFORMANT			ADDRESS			
no			132 16 7846		Frederick J. Casey			Bowie, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure											
4129 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) Arteriosclerotic heart disease											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
			19								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion on death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
22b. DATE SIGNED											
10-29-68											
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
John Kehoe MD.			Riverdale, Md.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			Nov 1, 1968		St Joseph's Cemetery			Boston Suffolk Mass.			
24. FUNERAL DIRECTOR						ADDRESS			25a. REC'D BY REGISTRAR		
P. Gasch's Sons						Hyattsville, Md.			DATE NOV 1 1968		
									25b. REGISTRAR'S SIGNATURE		
									Charles Judge		

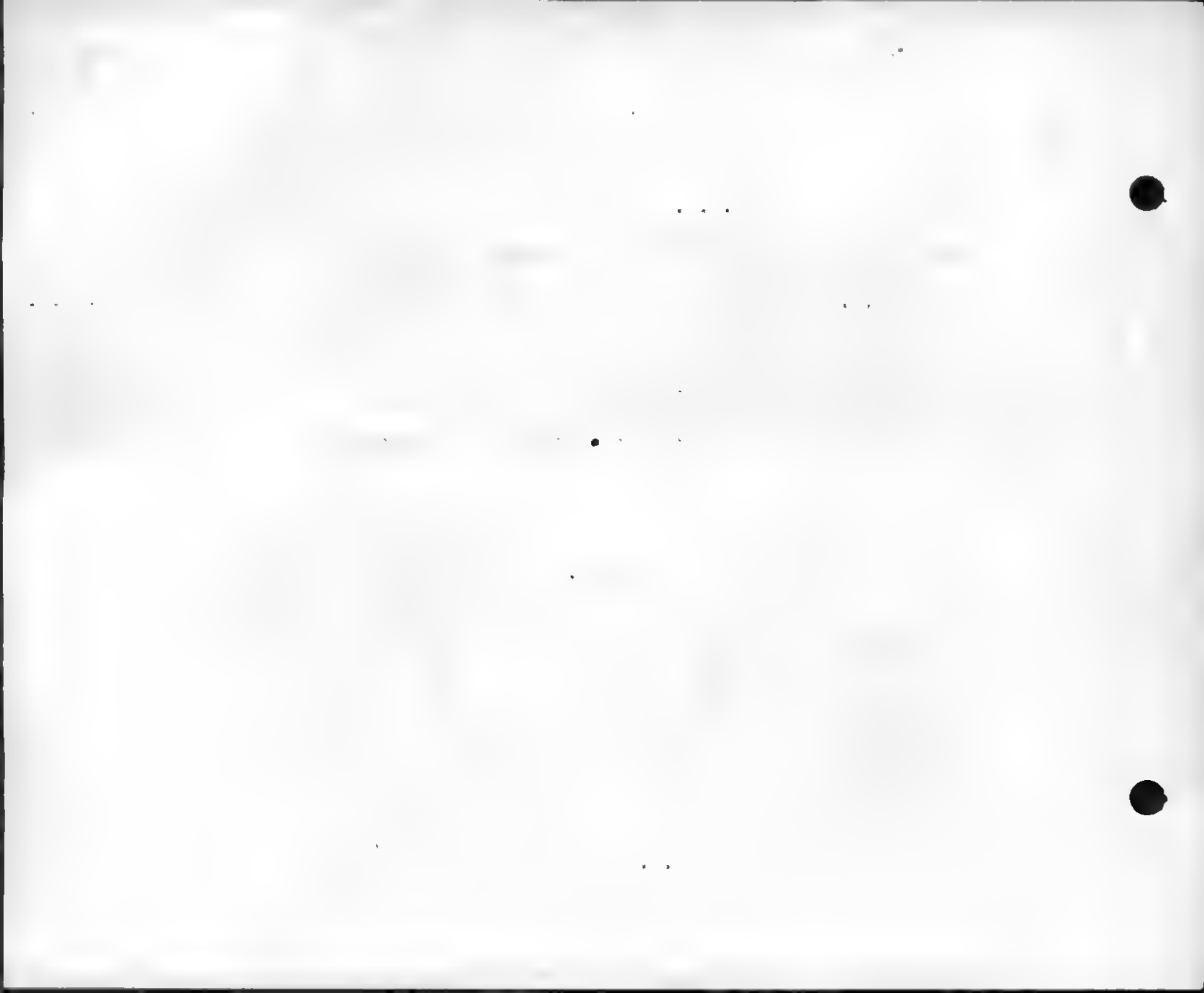


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
304A REV 1-68

14832		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		CERTIFICATE OF DEATH		14841			
1 DECEASED NAME (Type or print) First Middle Last <b>Cassie B. Cash</b>			2a DATE OF DEATH Month Day Year <b>October 11, 1968</b>			2b HOUR <b>12:45 P.M.</b>			
3 SEX <b>Female</b>		4 RACE <b>Negro</b>		5 DATE OF BIRTH <b>7/1/1908</b>		6 AGE (in years last birthday) <b>60</b> YRS			
7a BIRTHPLACE (State or foreign country) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH <b>Prince Georges</b> Md.			
10 CITY OR TOWN OF DEATH <b>Glenn Dale</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Glenn Dale Hospital</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Domestic</b>		12b KIND OF BUSINESS OR INDUSTRY <b>--</b>		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>D.C.</b>			13b. COUNTY <b>Washington</b>		13c INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13e STREET AND NUMBER <b>1207 New Jersey Ave. N.W.</b>		
14 FATHER'S NAME First Middle Last <b>John Cash</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Missie Smith</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, (unknown) <b>No</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO <b>2-37-052654</b>		17 INFORMANT <b>Decedent</b>			Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma of cervix with metastases</b> <b>180X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>171X</b> (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>onset 1967</b>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Chronic urinary tract infection.</b>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year <b>19</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f LOCATION Street or R.F.D. No City or Town County State					
22a I certify that (he) (this hospital) attended the deceased from <b>4/24/</b> , 19 <b>68</b> , to <b>10/11/</b> , 19 <b>68</b> , that (he) (we) lost saw the deceased alive on <b>10/11/68</b> 19 <b>68</b> , and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above, (he) (we) (did) (did not) view the body after death									
22b SIGNATURE <b>Moe Weiss</b>				DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED <b>10/11/1968</b>			
22d. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M.D.</b>				22e. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Maryland</b>					
23a BURIAL, CREMATION, OR OTHER DISPOSAL <b>Burial</b>		23b. DATE <b>10-18-68</b>		23c NAME OF CEMETERY OR CREMATORY <b>7 Harmony Memorial</b>		23d LOCATION (City or Town) (County) (State) <b>Landover Md.</b>			
24. FUNERAL DIRECTOR <b>W.W. Chamber</b>				ADDRESS <b>Wash D.C.</b>		25a REC'D BY REGISTRAR <b>OCT 23 1968</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



FOR STATE  
HEALTH DEPT.

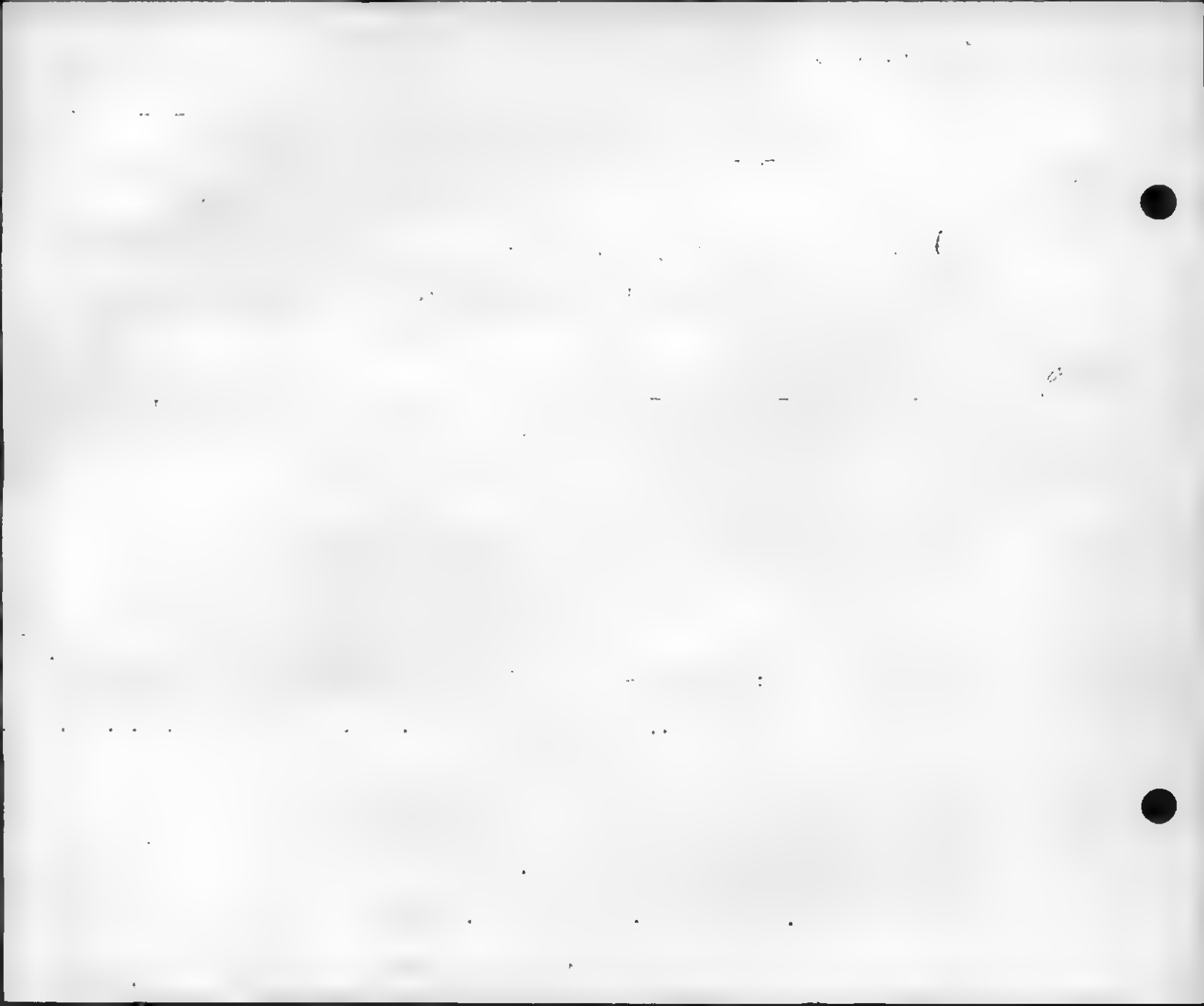
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14833

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14842

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month Day Year			2b. HOUR		
Charles Donald Catterton						10-28-68			192:40			am		
3 SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD			2d. HOUR			
Male	White	5-28-1940	28 YRS	MONTHS	DAYS	HOURS	MIN	10-28-68			192:40 am			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			12b. KIND OF BUSINESS OR INDUSTRY		
Maryland			USA						Prince George's			Construction		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY					
Cheverly			Prince George Hospital			Carpenter								
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER		
Maryland			Prince George's			District Heights			YES <input type="checkbox"/> NO <input type="checkbox"/>			2410 Rochelle Avenue		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME											
Sommers			O'Dell			Beulah			Catterton					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
- Yes -			1961 - 1965			217-38-5958			Mrs Beulah Wilkerson			9710 GlenView Drive Clinton, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))														
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Laceration of brain														
DUE TO, OR AS A CONSEQUENCE OF Trauma - auto accident														
(b)														
DUE TO, OR AS A CONSEQUENCE OF														
(c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)														
8234														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?					
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
tree.			9:57pm 10-24-1968			Driver of car which ran off road and struck a								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK			21e. PLACE OF INJURY (At home, farm street factory office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
Enterprise Rd., s miles			south of Rt. 450, Mitchellville, P.G. Co., Md.											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
Burial			Oct. 31, 1968			Mt. Harmony Chr. Cemetery Owings			Calvert Maryland					
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Hutchins Funeral Home			Owings, Maryland			DATE OCT 31 1968			Charles Judge					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV

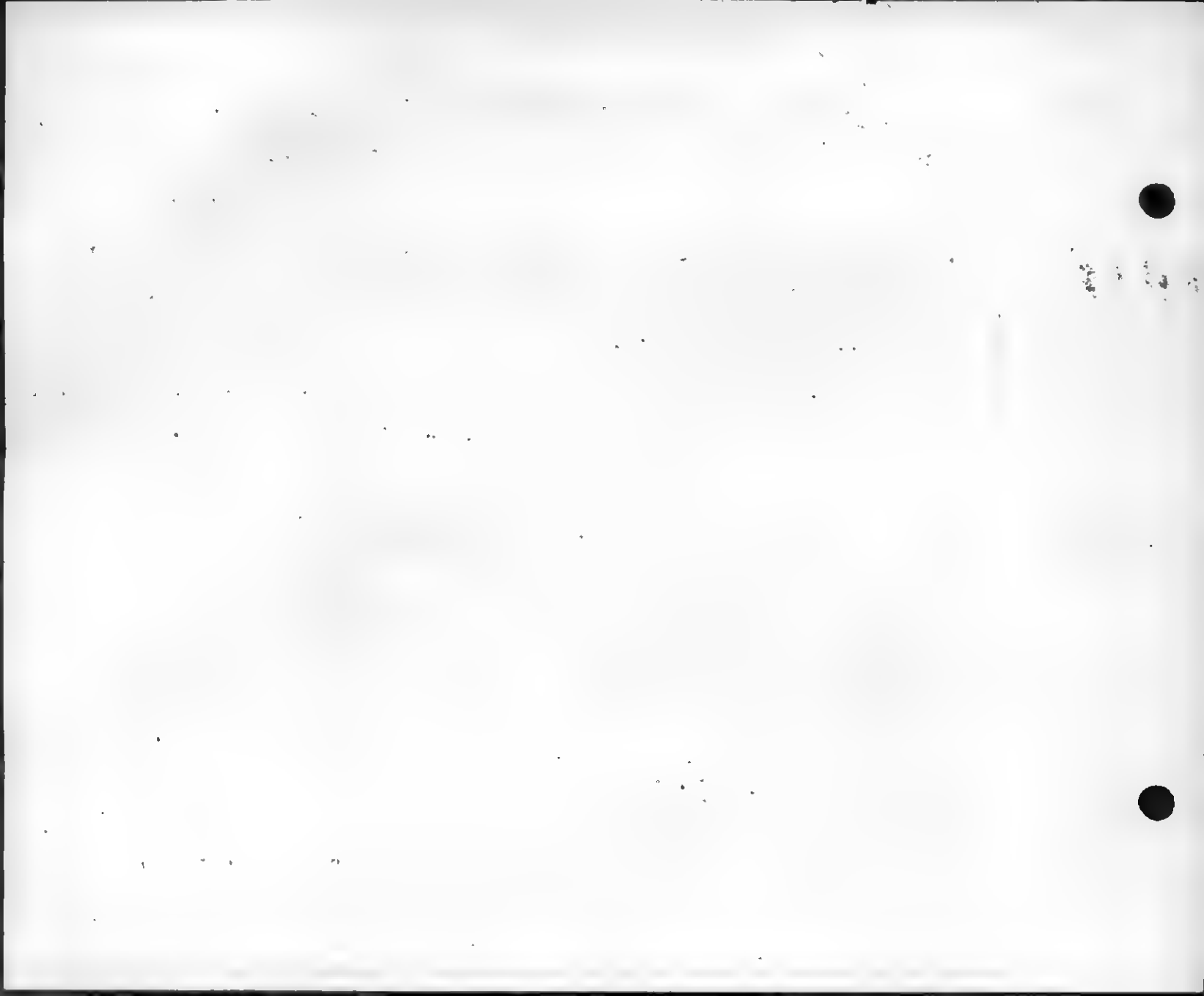
14836

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14843

1 DECEASED-NAME (Type or print) <sup>First</sup> <u>LUCILE</u> <sup>Middle</sup> <u>S.</u> <sup>Last</sup> <u>CAWTHORNE</u>			2a. DATE OF DEATH <u>October</u> <sup>Month</sup> <u>11</u> <sup>Day</sup> <u>1968</u> <sup>Year</sup>		2b. HOUR <u>M</u>
3. SEX <u>Female</u>	4 RACE <u>White</u>	5. DATE OF BIRTH <u>July 16 1878</u>		6. AGE (In years last birthday) <u>90</u> YRS.	IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u> IF UNDER 24 HRS HOURS <u></u> MIN <u></u>
7a. BIRTHPLACE (State or foreign country) <u>Ga.</u>	7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <u>Prince George's</u> Md		
10. CITY OR TOWN OF DEATH <u>Mt. Rainier</u>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>3306 33rd Street</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Clerk</u>	12b. KIND OF BUSINESS OR INDUSTRY <u>Drug</u>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <u>Maryland</u>	13b. COUNTY <u>Prince George's</u>	13c. CITY OR TOWN <u>Mt. Rainier</u>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <u>3306 33rd Street</u>	
14. FATHER'S NAME <sup>First</sup> <u>William</u> <sup>Middle</sup> <u>D.</u> <sup>Last</sup> <u>Stockman</u>		15. MOTHER'S MAIDEN NAME <sup>First</sup> <u>Mary</u> <sup>Middle</sup> <u>Etta</u> <sup>Last</sup> <u>Shaw</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <u>No</u> (If yes give way or dates of service)		16b. SOCIAL SECURITY NO. <u>212 24 4274</u>	17. INFORMANT <u>George S Cawthorne</u> Address <u>Washington, D.C.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>acute cerebral thrombosis</u> <u>4339</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>cerebral arteriosclerosis</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <u></u> Month <u></u> Day <u></u> Year <u>19</u> P.M. <u></u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED <u>While</u> <input type="checkbox"/> <u>Not while</u> <input type="checkbox"/> at work <u></u>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. <u></u> City or Town <u></u> County <u></u> State <u></u>	
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug</u> , 1967, to <u>Oct 11, 1968</u> , that (I) (we) last saw the deceased alive on <u>Sept 13, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Don B. Cameron</u> DEGREE <u></u> ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22c. DATE SIGNED <u>Oct 11, 1968</u>	
22d. PHYSICIAN'S NAME (Type) <u>DON B. CAMERON</u>		22e. ADDRESS <u>Mt. Rainier, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>10/14/1968</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City or Town) <u>Tolmar Manor, Maryland</u> (County) <u></u> (State) <u></u>	
24. FUNERAL DIRECTOR <u>Valley's Funeral Home</u>		ADDRESS <u>Mt. Rainier, Md</u>		25a. REC'D BY REGISTRAR <u></u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>
				DATE <u>OCT 15 1968</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Items 5 & 6 Film 06

11/14/68 kk

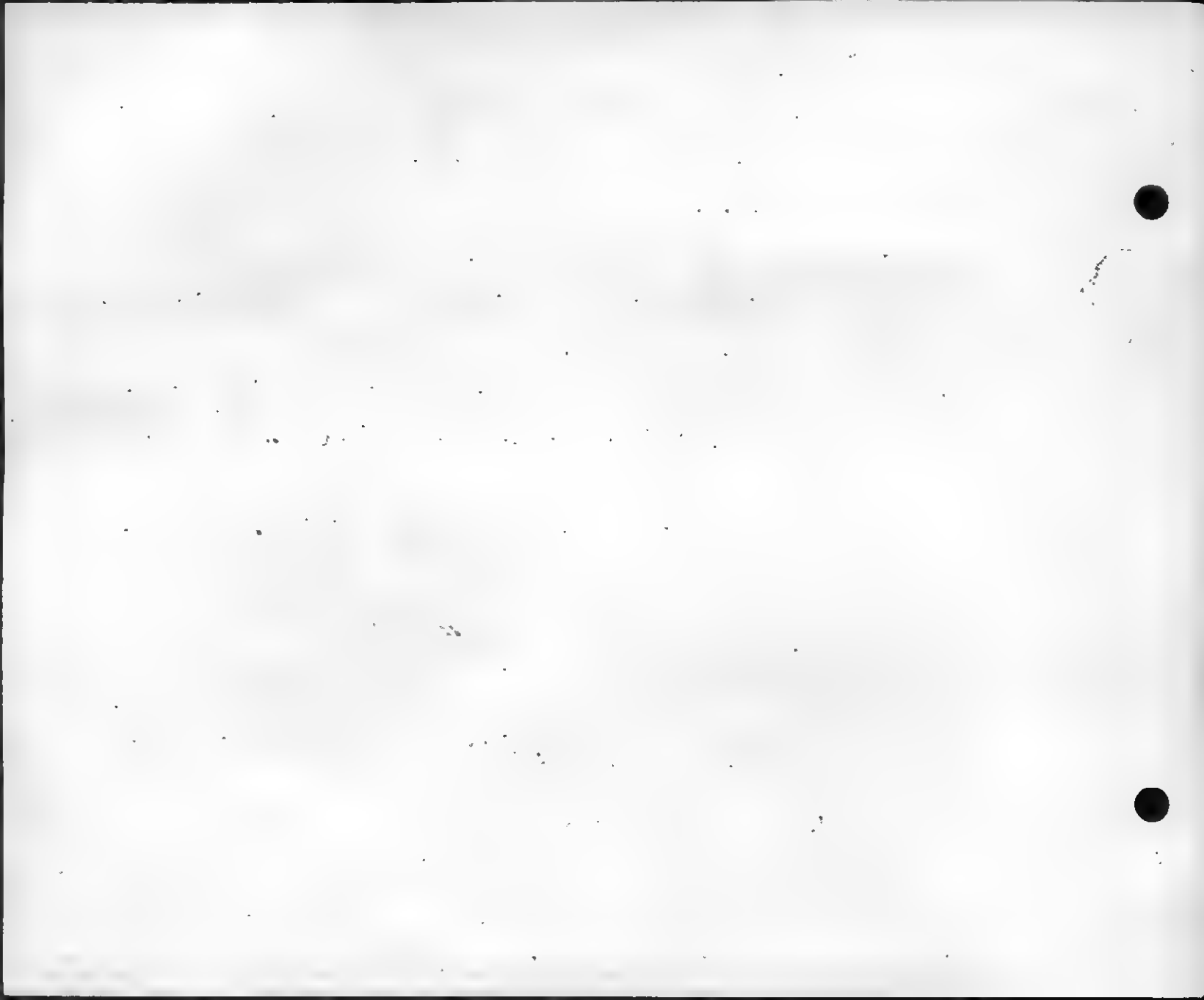
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14835

CERTIFICATE OF DEATH

14844

1. DECEASED NAME (Type or print) First Middle Last <b>Theodore John Chaconas</b>			2a. DATE OF DEATH Month Day Year <b>10 31 68</b>			2b. HOUR M <b>10</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>1901 Oct. 2, 1902</b>		6. AGE (in years last birthday) <b>66 67 YRS</b>		F UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince Georges</b> Md			
10. CITY OR TOWN OF DEATH <b>Hyattsville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince George Gen.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Prince George</b>		13c. CITY OR TOWN <b>Bladensburg</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>6011 Emerson St.</b>	
14. FATHER'S NAME First Middle Last <b>Peter J. Chaconas</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Dianna Rony</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown (If yes give war or dates of service) <b>No</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT <b>Frieda Chaconas</b>		Address <b>Same as 13c &amp; e</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute coronary thrombosis</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) <b>arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>2211</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 1966</b> to <b>Oct 3, 1968</b> , that (I) (we) last saw the deceased alive on <b>Aug 28, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Don B. Cameron</b>				22c. DATE SIGNED <b>Nov. 1, 1968</b>					
22d. PHYSICIAN'S NAME (Type) <b>Don B. Cameron M.D.</b>				22e. ADDRESS <b>3503 Perry St. Mt. Rainer, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE <b>11/1/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lee's Crematory</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington, D.C. 20002</b>			
24. FUNERAL DIRECTOR <b>Lee Funeral Home</b>				ADDRESS <b>Washington, D.C.</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 4 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	



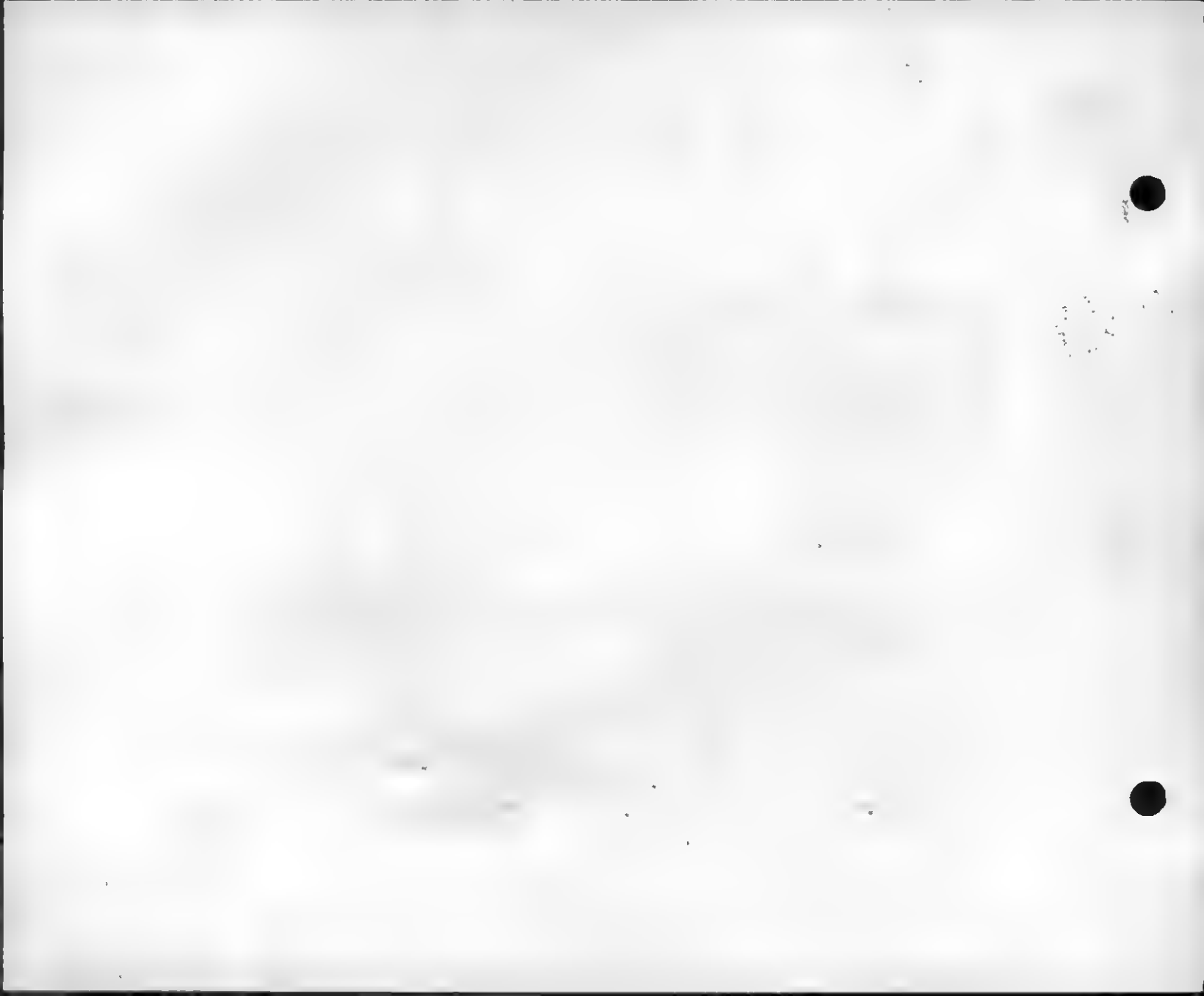
14836

CERTIFICATE OF DEATH

14845

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print) <b>Thomas Chase</b>		First Middle Last		2a. DATE OF DEATH 10 Month 11 Day 1968 Year			2b. HOUR 10 P.M.		
3. SEX <b>Male</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH 9/10/1899			6. AGE (In years last birthday) 79 YRS.		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince Georges</b> Md.			
10. CITY OR TOWN OF DEATH <b>Clinton, MD.</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Pine View Gardens</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Laborer</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Washington D.C.</b>		13b. COUNTY <b>5408 Wheelbar Rd SE</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER <b>5408 Wheelbar Rd SE</b>			
14. FATHER'S NAME First Middle Last <b>Chase</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Maggie</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown <input type="checkbox"/> (If yes give war or dates of service)					
16b. SOCIAL SECURITY NO <b>578-10-048</b>		17. INFORMANT <b>Sam Thomas Chase Jr.</b>					Address <b>Same</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Insufficiency</b> <b>4119</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>vascular collapse</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 10, 1968</b> to <b>Oct 11, 1968</b> , that (I) (we) last saw the deceased alive on <b>Oct 11, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE <b>Harry G. Gindley</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>Oct 11 1968</b>			
22d. PHYSICIAN'S NAME (Type) <b>H. G. GINDLEY</b>		22e. ADDRESS <b>4601 Nichols Ave SE</b>							
23a. BURIAL, CREMATION, REMOVAL, (Specify) <b>Burial</b>		23b. DATE <b>10/15/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington, D.C.</b>			
24. FUNERAL DIRECTOR <b>John T. Stewart</b>		24a. REC'D BY REGISTRAR <b>DATE</b>		24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		24c. ADDRESS <b>Stewart Funeral Home - 4001 Benning Rd.</b>			



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
10M REV 1-68

14837 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										14846	
Item 86, Film 405 10/18/68 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			Month Day Year		
James Edward Christian						ESTIMATED <input checked="" type="checkbox"/> MATED <input type="checkbox"/>			3 19 68		
3. SEX	4 RACE	5. DATE OF BIRTH	6 AGE (in years)	IF UNDER 1 YEAR		IF UNDER 24 MRS.		2c DATE PRONOUNCED DEAD			2d
M	W	4 Dec. 68	95	MONTHS	DAYS	HOURS	MIN	Month Day Year			P M
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH		
Greenville, Va			USA						Prince George Md		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Clinton			Clinton Comm. Hospital								
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY			13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER		
			Washington						1634 Gale St. N.E.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
Thomas Christian			IRENE GRATEN								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT			ADDRESS		
						Alberta Christian W - Same as above					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)											
41 Heart failure										Minutes	
DUE TO, OR AS A CONSEQUENCE OF (b)											
Arteriosclerotic heart disease										2 yrs	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
4200 Diabetes mellitus-over 2 yrs.											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
CAUSE OF DEATH			HOUR A.M. P.M.								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
22b. DATE SIGNED											
10-3-64											
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
John Kehoe, M.D.			Riverdale			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			10-7-68			John Wesley Church			Aguasco, Md. P.O. Co.		
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Martell Adams			OCT 11 1968			Charles Judge					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14838

CERTIFICATE OF DEATH

14847

1. DECEASED-NAME (Type or print) <b>Frank T. Cinotti</b>			2a. DATE OF DEATH Month <b>10</b> Day <b>15</b> Year <b>68</b>			2b. HOUR <b>11:10</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Nov. 23, 1899</b>		6. AGE (in years last birthday) <b>68</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Wash., D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George Co.</b> Md.	
10. CITY OR TOWN OF DEATH <b>West Hyattsville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>6417 Sligo Parkway</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Contractor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Stone &amp; Brick</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Pr. George</b>		13c. CITY OR TOWN <b>W. Hyatts.</b>		13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
13e. STREET AND NUMBER <b>6417 Sligo Parkway</b>							
14. FATHER'S NAME First <b>John</b> Middle <b>B.</b> Last <b>Cinotti</b>			15. MOTHER'S MAIDEN NAME First <b>Louise</b> Middle <b>T.</b> Last <b>Zacarin</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>Unk.</b> (!! yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Cecilia M. Cinotti-wife Same as #13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the Liver</b> <b>1978</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>23 days</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>1978</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (the hospital) attended the deceased from <b>11/9</b> , 19 <b>48</b> , to <b>Oct. 15</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>Oct. 15</b> , 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Thomas F Collins</b>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>10/15/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>Thomas F Collins, M.D.</b>				22e. ADDRESS <b>2600 Queens Chapel Road, Hyattsville, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Oct. 18, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor, Maryland</b>	
24. FUNERAL DIRECTOR <b>Lee Fun. Home-300 4th St. NE Wash., D.C.</b>				25a. REC'D BY REGISTRAR <b>OCT 18 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	



14839

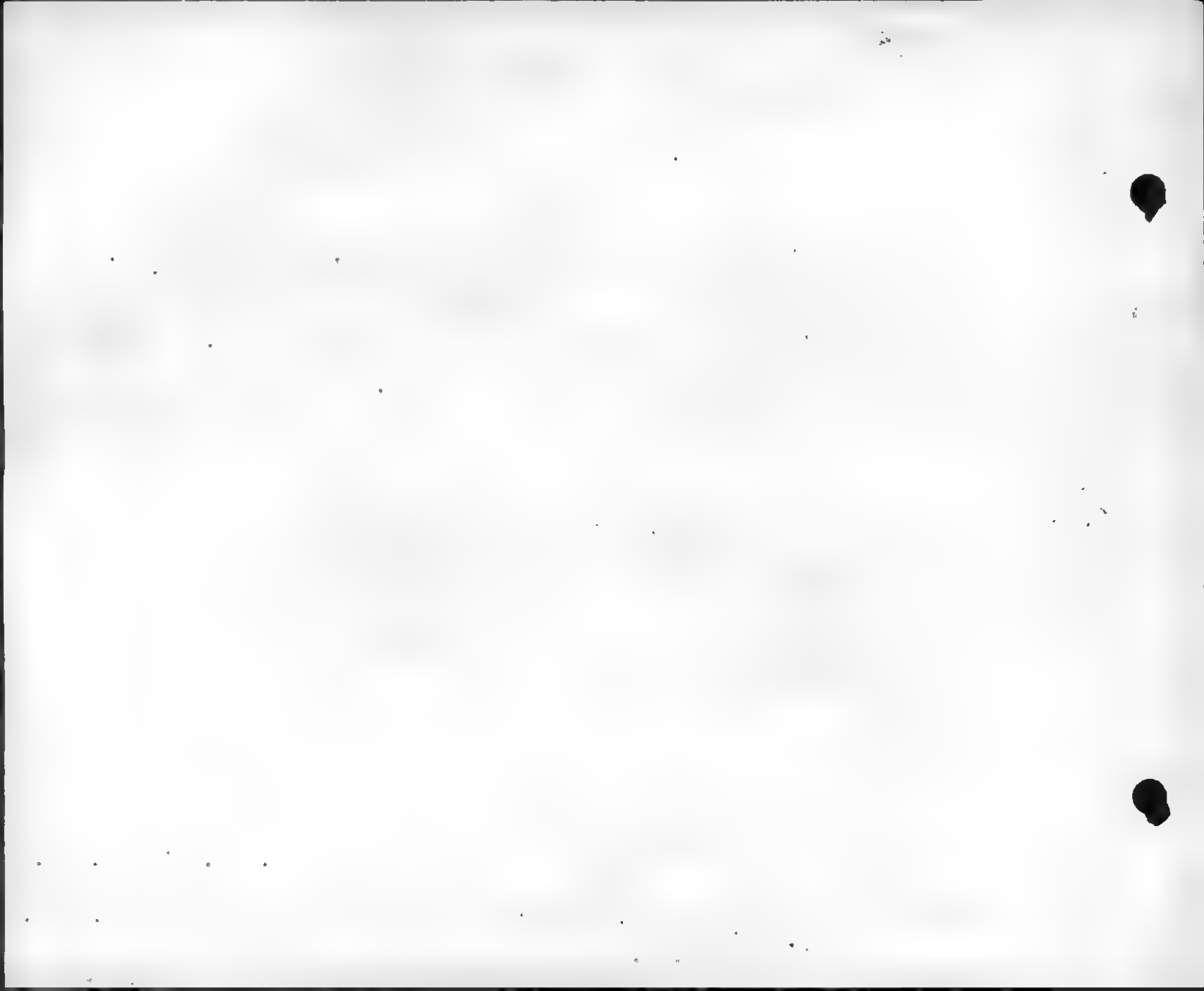
CERTIFICATE OF DEATH

14848

1. DECEASED-NAME (Type or print) <b>Harold J. Clay</b>			2a. DATE OF DEATH Month <b>Oct.</b> - Day <b>23</b> - Year <b>1968</b>			2b. HOUR <b>4:05<sup>PM</sup></b>	
3 SEX <b>male</b>		4 RACE <b>white</b>		5 DATE OF BIRTH <b>JAN. 18, 1892</b>		6 AGE (In years last birthday) <b>76</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>MINN.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Prince George</b> Md	
10 CITY OR TOWN OF DEATH <b>Nyattsville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Nyattsville Nursing Home</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Marketing Spec.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Ag. Culture Dept.</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution, give street address) STATE <b>Wash. D.C.</b>		13b. COUNTY <b>Wash. D.C.</b>		13c. CITY OR TOWN <b>Wash. D.C.</b>		13d. INSIDE CITY OR TOWN (If not in city or town, give street address) <b>2603 Monroe St.</b>	
14. FATHER'S NAME First <b>William</b> Middle <b>Clay</b> Last <b>Clay</b>			15 MOTHER'S MAIDEN NAME First <b>Ruth</b> Middle <b>S.</b> Last <b>Johnson</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>578-56-5341</b>		17. INFORMANT <b>Bessie E. Clay</b>		Address <b>same as above</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>1104 Coronary artery thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) storing the underlying cause lost (b) <b>coronary</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>coronary arteriosclerosis</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>4. diabetes mellitus</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>aug 1968</b> , to <b>Oct 23 1968</b> , that (I) (we) last saw the deceased alive on <b>Oct 5 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Don B. Cameron</b>		22c. DATE SIGNED <b>10-23-68</b>		22d. PHYSICIAN'S NAME (Type) <b>DON B. CAMERON</b>			
22e. ADDRESS <b>3503 Perry St.-Mt. Rainier, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10/25/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Prince Georges Co. Md.</b>	
24. FUNERAL DIRECTOR <b>The S.H. Hines Co.</b> <b>Washington, D.C.</b>				25a. REC'D BY REGISTRAR DATE <b>OCT 24 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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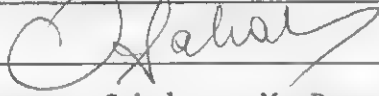

VR A 15  
30M REV. 11-23-68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print) First Middle Last MAGGIE V CLUTTER			2a. DATE OF DEATH Month 10 Day 9 Year 68			2b. HOUR 7:30 P.M.			
3 SEX Female		4. RACE White		5. DATE OF BIRTH 2/26/1884		6. AGE (In years last birthday) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md.			
10. CITY OR TOWN OF DEATH Oxon Hill		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 5800 Hempstead Dr.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housewife		12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Prince Geo		13c. CITY OR TOWN Oxon Hill		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5800 Hempstead Drive	
14. FATHER'S NAME First Middle Last Doc Mc Million				15. MOTHER'S MAIDEN NAME First Middle Last Eliza J. Davis					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO (If yes give war or dates of service) 236242480		17 INFORMANT Jessie Woofter			Address LaPlata, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GENERALIZED ASCVD 4104 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4221 (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Recurrent (D) parotid & minor salivary gland tumors									
19a. DATE OF OPERATION Sept 11 <sup>th</sup>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED (D) parotid tumor			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from Sept 4, 1968, to Oct 9, 1968, that (I) (we) lost the deceased alive on Sept 26, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
22b. SIGNATURE Louis M. Damiano MD				DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 10/9/68	
22d. PHYSICIAN'S NAME (Type) LOUIS M. DAMIANO				22e. ADDRESS 6001 Landover Rd					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10-12-1968		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland Maryland			
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Road Suitland Maryland				25a. REC'D BY REGISTRAR DATE OCT 14 1968		25b. REGISTRAR'S SIGNATURE John A. Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <span>14841</span> <span>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>14850</span> </div> <div style="text-align: center; font-weight: bold;">CERTIFICATE OF DEATH</div>											
1. DECEASED NAME (Type or print)			First Middle Last <b>Mason Howard Cobb</b>			2a. DATE OF DEATH Month <b>Oct.</b> Day <b>30</b> , Year <b>1968</b>			2b. HO. JR. <b>3:50 A</b>		
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>Feb. 3, 1920</b>			6. AGE (In years last birthday) <b>48</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>Md</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George's Md</b>					
10. CITY OR TOWN OF DEATH <b>Cheverly</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo. Gen'l Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Auto garage self employed</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>			13b. CITY OR TOWN <b>Prince George's Landover</b>		13c. IN'S DE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>Church Road, P.O. Box 1241</b>				
14. FATHER'S NAME First Middle Last <b>Josias Mason Cobb</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Louise Seauberlich</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <b>yes</b> (If yes, give war or dates of service) <b>W W II</b>			16b. SOCIAL SECURITY NO. <b>579 12 3358</b>		17. INFORMANT Address <b>Ethel A Cobb Bladensburg, Md.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Nutritional cirrhosis of the liver with fatty metamorphosis, advanced.</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hepatic failure.</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) <del>the hospital</del> attended the deceased from <b>Oct. 27, 1968</b> to <b>Oct. 30, 1968</b> , that (I) <del>was</del> last saw the deceased alive on <b>Oct. 30, 1968</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> (did) <del>not</del> view the body after death.											
22b. SIGNATURE 						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>Oct. 30, 1968</b>			
22d. PHYSICIAN'S NAME (Type) <b>Ohannes Sahakyan, M. D.</b>						22e. ADDRESS <b>6001 Landover Rd., Cheverly, Md. 20785</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Nov 2, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor Pro Geo Md.</b>				
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>				ADDRESS <b>Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 4 1968</b>		25b. REGISTRAR'S SIGNATURE 			

MEDICAL CERTIFICATION

1000000



**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Any delay is unnecessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Pages 5 may be retained for your files.

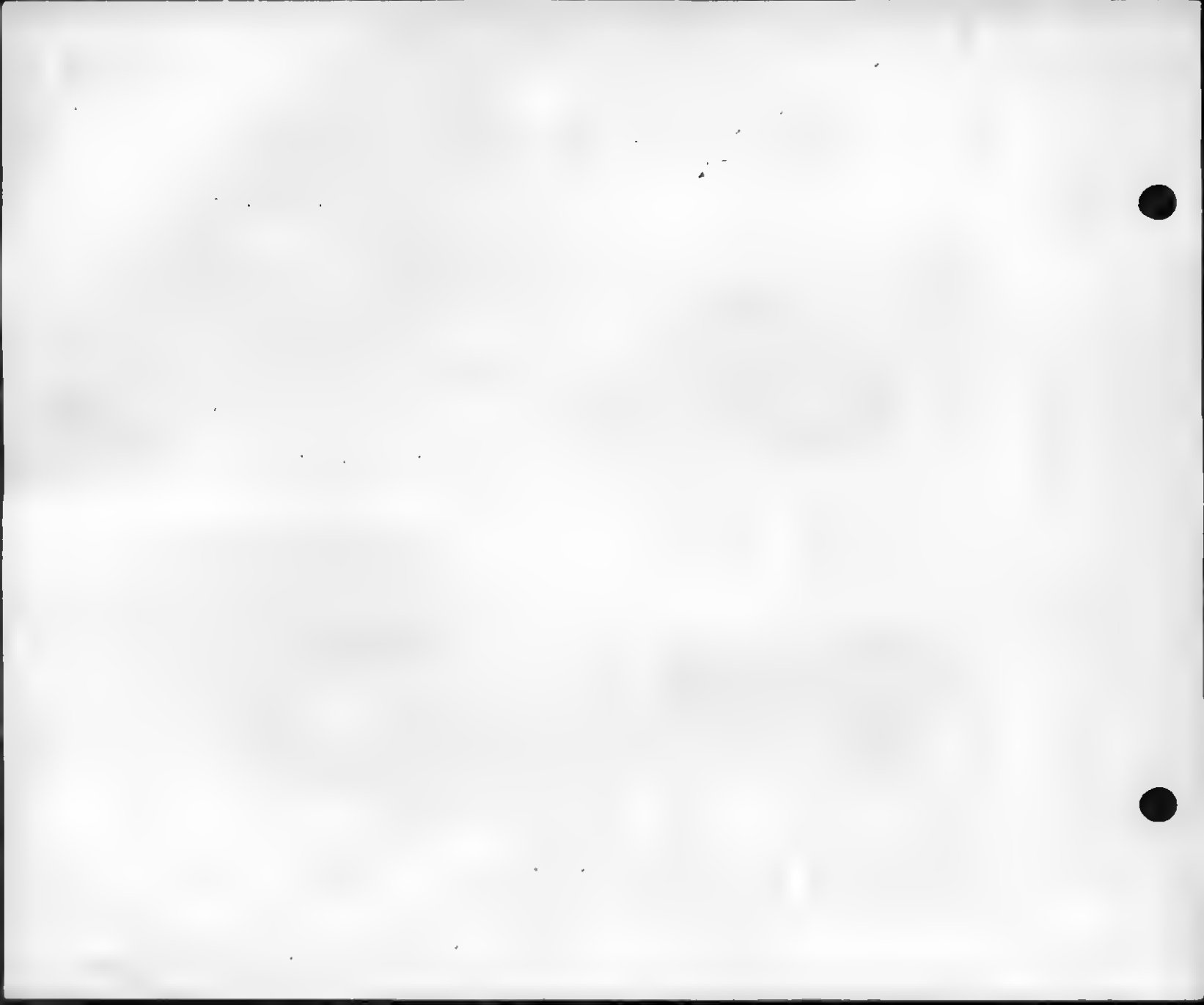
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

## TO DEPUTY

VR A15ME (5)  
10M REV 1/68

## 14851

1. DECEASED NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		Month	Day	Year	2b. HOUR
Ella		Mary		Cookson				DEATH MATED <input checked="" type="checkbox"/>		10	22	68	9:35am
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		Month	Day	Year	2d. HOUR
Female	White	8-13-1887	81 YRS	MONTHS	DAYS	HOURS	MIN	10		22	68	10:15am	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH							
Pa		U S A		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Prince George's						Md	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if ret red.)		12b. KIND OF BUSINESS OR INDUSTRY							
Cheverly		Prince George Hospital		housewife		home							
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13e. STREET AND NUMBER							
Maryland		Prince George's		Greenbelt		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		39 G Ridge Road					
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last				
Timothy O' Herron						Anna Mary Holleran							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
no		169 05 4388		Charles Joseph Cookson		Greenbelt, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Heart failure</u> <u>4</u> DUE TO, OR AS A CONSEQUENCE OF <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>unknown</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>4200</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?					
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f. LOCATION Street or R.F.D. No		City or Town		County		State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>						22b. DATE SIGNED					
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						10-22-68					
John Kehoe MD		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
Riverdale, Md.		ADDRESS (Street, city, town, or county)											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)			
Burial		Oct 25, 1968		Gate of Heaven cemetery		Wheaton Montgomery				Md.			
24. FUNERAL DIRECTOR		F. Gasch's Sons						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
		Hyattsville, Md.						OCT 25 1968		Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

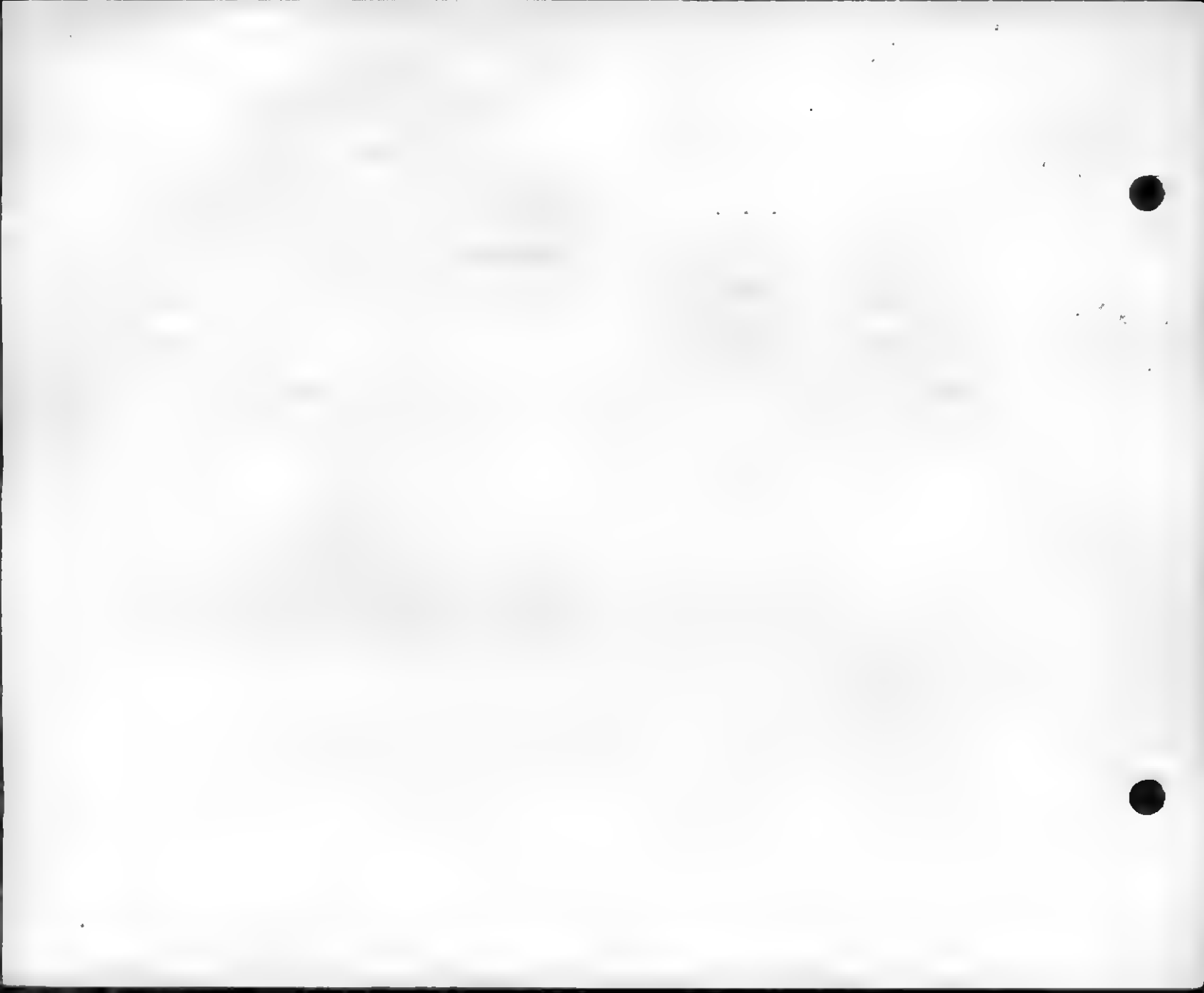
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

14852

14843

1. DECEASED-NAME (Type or print) <b>PEARL E COUTURE</b>			2a. DATE OF DEATH Month <b>OCTOBER</b> Day <b>21</b> Year <b>1968</b>			2b. HOUR <b>5:15 PM</b>				
3. SEX <b>FEMALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH <b>4 Mar 1896</b>		6. AGE (In years last birthday) <b>72</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		
7a. BIRTHPLACE (State or foreign country) <b>NEW YORK</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>PRINCE GEORGE'S</b> Md				
10. CITY OR TOWN OF DEATH <b>ANDREWS AFB</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MALCOLM GROW USAFHOSP</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before address) <b>NEW YORK STATE WARREN</b>			13c. CITY OR TOWN <b>GLENS FALLS</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>RR 1 BOX 138</b>			
14. FATHER'S NAME First Middle Last <b>THEODORE KILMER</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>CLARISSE VAN DUSEN</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>0-87-01-8682</b>		17. INFORMANT <b>2046 DORIS RD, AUGUSTA GA</b> <b>RAYMOND B COUTURE SR</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCT ACUTE</b> <b>157.9</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Aspiration of gastric contents</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Carcinoma of the Pancreas</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>1 1/2 years</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>157X</b>										
9a. DATE OF OPERATION		9b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>common duct obstruction</b>			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>16 SEP, 1968</b> , to <b>21 OCT, 1968</b> , that (I) (we) lost saw the deceased alive on <b>21 OCT, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE <i>Wm. J. Kilmer</i>				DEGREE		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>23 OCT 68</b>		
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10-24-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Natl.</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington Va.</b>				
24. FUNERAL DIRECTOR <b>Wilhelm Funeral Home 4308 Suitland Rd. S. E.</b>				25a. REC'D BY REGISTRAR <b>NOV 1 1968</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

14846

14853

1. DECEASED NAME (Type or print) <b>Rose ANN COX.</b>			2a. DATE OF DEATH Month <b>10</b> Day <b>28</b> Year <b>1968</b>			2b. HOUR <b>8:20</b> AM	
3 SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>3-17-86</b>		6. AGE (In years last birthday) <b>82</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>IRELAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince Georges</b> Md	
10. CITY OR TOWN OF DEATH <b>Clinton</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Pine View Gardens.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>2229 Hindle Lane Prince Georges</b>		13b. COUNTY <b>Bowie</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>2229 Hindle Lane</b>	
14. FATHER'S NAME First Middle Last <b>John Culligan</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Anne Smith</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>No</b>		16b. SOCIAL SECURITY NO <b>266-24-5437A</b>		17. INFORMANT Address <b>Catherine Kirk 2229 Hindle Lane, Bowie Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Circulatory Collapse</b> <b>4010</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (b) <b>Chronic Kidney Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Essential Hypertension</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home farm street factory, office building, etc.)		21f. LOCATION Street or RFD No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>7:10</b> , 19 <b>68</b> , to <b>10-28</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>10-28</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Alfred P. Laperon, M.D.</b> DEGREE <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <b>10/28/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>ALFRED P. LAPERON, MD</b>		22e. ADDRESS <b>Clinton, MD</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10-31-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington D. C.</b>	
24. FUNERAL DIRECTOR <b>Wilhelm Funeral Home 4308 Cui Land Rd. S. E.</b>				25a. REC'D BY REGISTRAR DATE <b>NOV 4 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

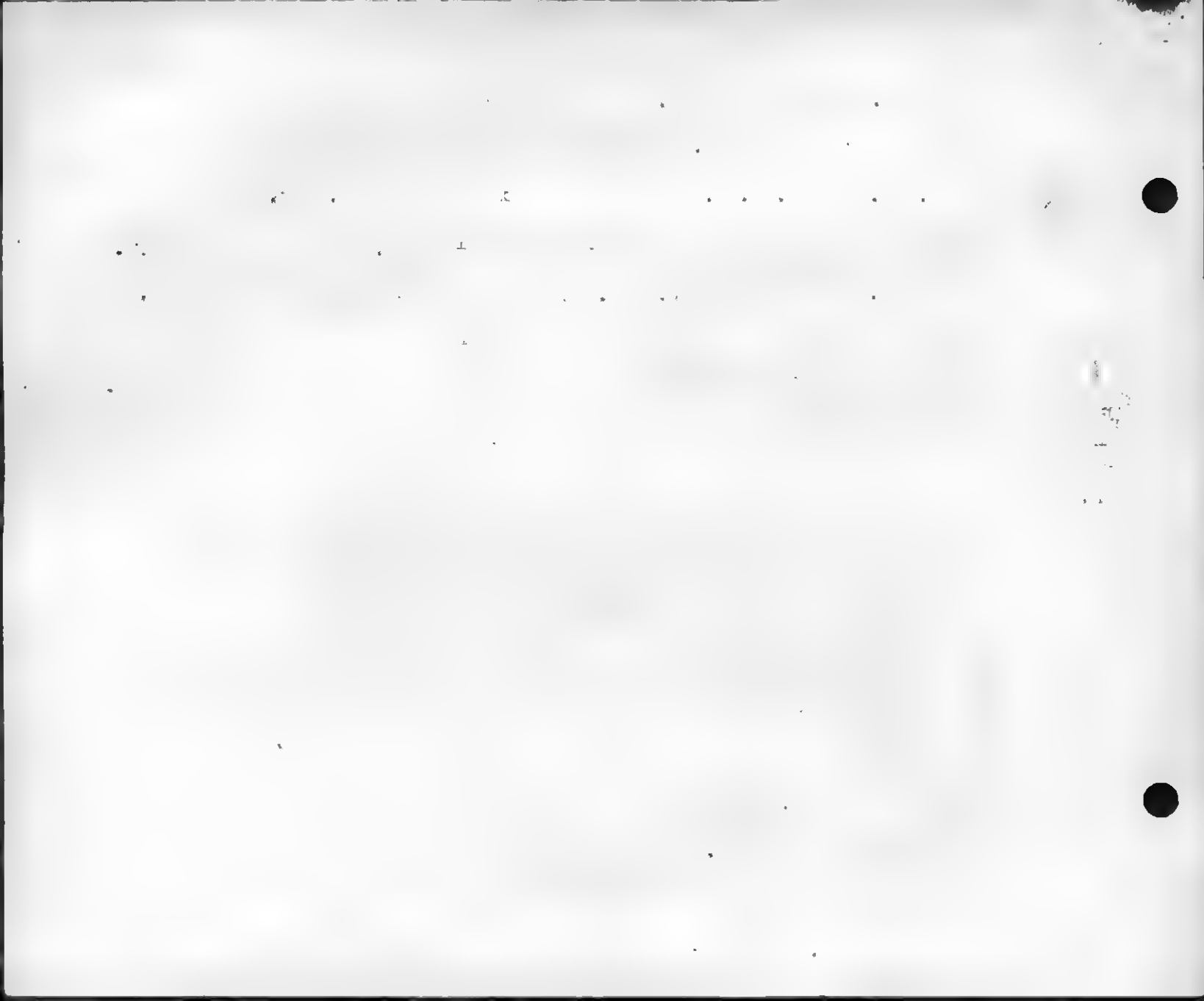


**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed with n 24 hours after death. Any delay is necessary, please execute the certificate, writing the ward "pending in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PG-3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14854

VR A15ME (S)  
10M REV 1/68

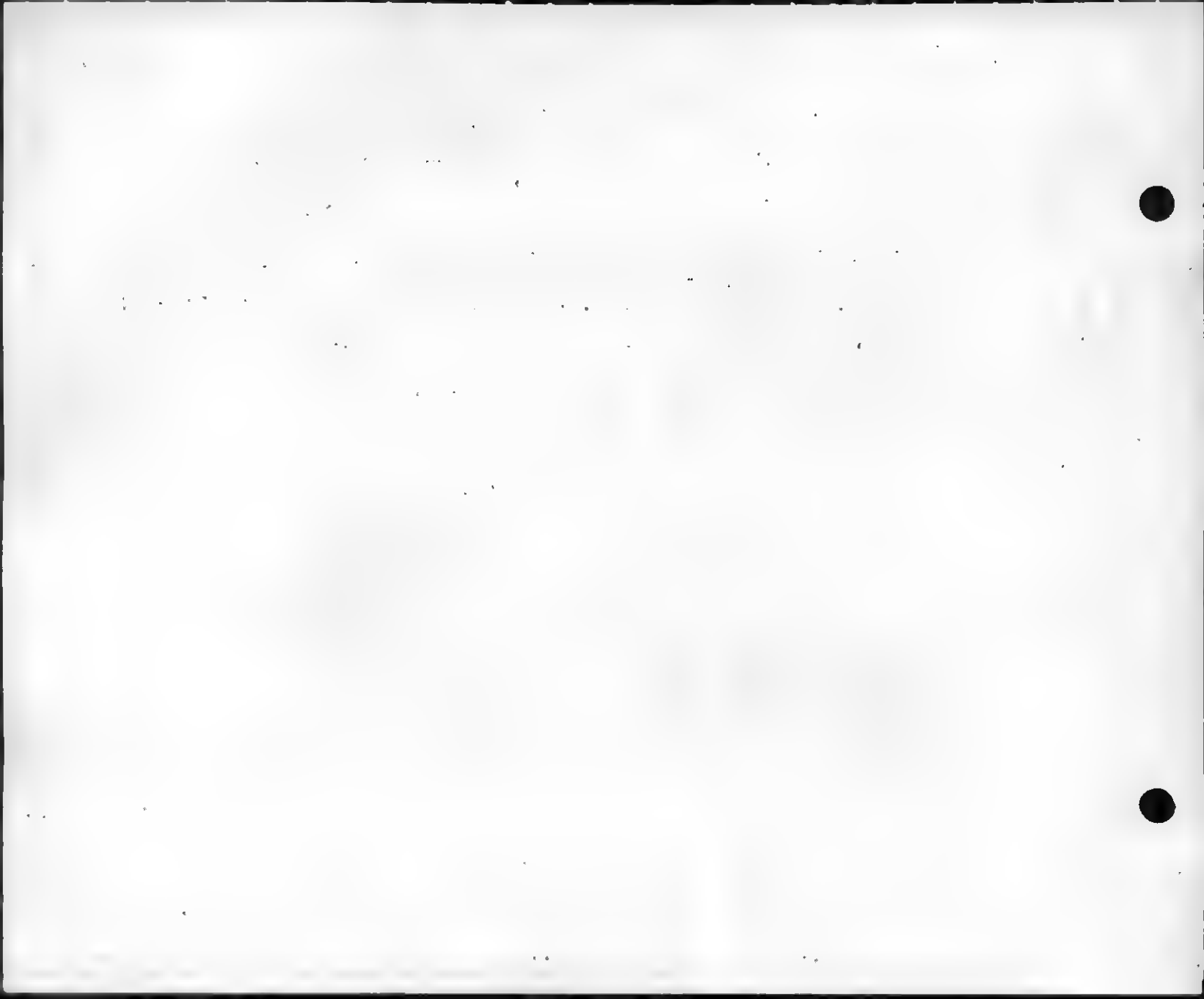




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
304A REV 1/68

<div style="display: flex; justify-content: space-between;"> <div> 14846  <div style="display: flex; justify-content: space-between;"> <div>1 DECEASED-NAME (Type or print) First Middle Last</div> <div>2a. DATE OF DEATH Month Day Year</div> <div>2b. HOUR P M</div> </div> </div> <div> DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  <b>CERTIFICATE OF DEATH</b>  14855 </div> </div>											
1 DECEASED-NAME (Type or print) First Middle Last Stacey O. Daigneault			2a. DATE OF DEATH 10 Month 2 Day 68 Year			2b. HOUR 4:30 P M					
3. SEX Male		4. RACE White		5. DATE OF BIRTH 7-4-98		6. AGE (In years last birthday) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Vermont		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md					
10. CITY OR TOWN OF DEATH Riverdale, Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Eugene Leland Memorial		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired clerk				12b. KIND OF BUSINESS OR INDUSTRY Hotel			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Prince G.		13c. CITY OR TOWN Hyatts.		3d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1508 Madison St.			
14. FATHER'S NAME First Middle Last Joseph Daigneault			15. MOTHER'S MAIDEN NAME First Middle Last Ruth Hubbard								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 579 01 6384A		17. INFORMANT Address Zella C Daigneault Hyattsville, Md..							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4124 CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF ARTERIOSCLEROTIC C.V. DISEASE (b) UNKNOWN DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 MO	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4221 PULM. EMPHYSEMA											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 27 SEP, 1968, to 2 OCT., 1968, that (I) (we) last saw the deceased alive on 2 OCT., 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE C.J. Houmann		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2 OCT. 1968	
22d. PHYSICIAN'S NAME (Type) C-J. HOUMANN		22e. ADDRESS RIVERDALE MD.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/5/68		23c. NAME OF CEMETERY OR CREMATORY Forest Lawn Cemetery		23d. LOCATION (City or Town) (County) (State) Norfolk Norfolk Va.					
24. FUNERAL DIRECTOR F. Gasch's Sons				ADDRESS Hyattsville, Md		25a. REC'D BY REGISTRAR DATE OCT 7 1968		25b. REGISTRAR'S SIGNATURE J Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 15  
30M REV

<div style="display: flex; justify-content: space-between;"> <span>14847</span> <span>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>14856</span> </div> <div style="text-align: center;"> <b>CERTIFICATE OF DEATH</b> </div>													
1. DECEASED NAME (Type or print) <b>Alvah</b>			First Middle Last <b>Daniels</b>			2a. DATE OF DEATH Month <b>October</b> Day <b>1</b> Year <b>68</b>			2b. HOUR <b>9:30</b> P.M.				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>July 22, 1911</b>			6. AGE (In years last birthday) <b>57</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN <b></b>		
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince Georges</b> Md							
10. CITY OR TOWN OF DEATH <b>Cheverly</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Georges</b>			12a. USUAL OCCUPATION (Kind of work done during most of life or retired.) <b>house wife</b>			12b. KIND OF BUSINESS OR OCCUPATION <b>OWN HOME</b>				
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Balt.</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>1823 Berrywood Rd.</b>				
14. FATHER'S NAME First Middle Last <b>Sewell Evans</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Pearl Webster</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <b>NO</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT Address <b>Charles G. Daniels (same as # 13)</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Lung.</b> <b>1621</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic heart disease.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Dysplastic Carcinoma.</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19. DATE OF OPERATION													
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>August</b> , 19 <b>66</b> , to <b>Sept 24</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>Sept 24</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <b>Medical Examiner Notified &amp; Approved</b>													
22b. SIGNATURE <b>Jamshed Hamed MD</b> DEGREE <b>MD</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED <b>10/2/68.</b>			
22d. PHYSICIAN'S NAME (Type) <b>JAMSHED HAMED.</b>										22e. ADDRESS <b>204-E 70TH Rd FOXBORO MA</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>10-4-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. PAUL'S CEMETERY</b>			23d. LOCATION (City or Town) (County) (State) <b>LYNNON MA MD</b>					
24. FUNERAL DIRECTOR ADDRESS <b>Heroy Webster Princess Anne</b>										25a. REC'D BY REGISTRAR DATE <b>OCT 7 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14848

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

14857

1. DECEASED NAME (Type or print) First Middle Last <b>William Henry DeVaughn</b>			2a. DATE OF DEATH Month Day Year <b>Oct. 27 1968</b>		2b. HOUR <b>12:45 M</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>April 10, 1881</b>		6. AGE (In years last birthday) <b>87</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Prince Georges</b> Md.		
10. CITY OR TOWN OF DEATH <b>Cheverly</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Pr. Geo's Gen. Hosp:</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Tobacco Farmer</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Md.</b>	13b. COUNTY <b>Pr/Geo's</b>	13c. CITY OR TOWN <b>Upper Marlboro</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>4801 Old Largo Rd.</b>	
14. FATHER'S NAME First Middle Last <b>Joseph -- DeVaughn</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>May -- Tayman</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16b. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>Margaret Pushee-Upper Marlboro Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Sclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>Aug</b> , 19 <b>68</b> , to <b>27 Oct</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>27 Oct</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Robert B. Sasscer</b>		22c. DATE SIGNED <b>Oct. 27, 1968</b>		22d. PHYSICIAN'S NAME (Type) <b>Robert B. Sasscer, M.D.</b>	
22e. ADDRESS <b>Upper Marlboro, Md. 20870</b>		22f. ADDRESS <b>Upper Marlboro, Md. 20870</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>10/30/68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cem:</b>		23d. LOCATION (City or Town) (County) (State) <b>Bladensburg, P. Geo., Md.</b>	
24. FUNERAL DIRECTOR <b>Ritchie Bros. Upper Marlboro, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 12 1968</b>		25b. REG. STAFF'S SIGNATURE <b>Charles Judge</b>	

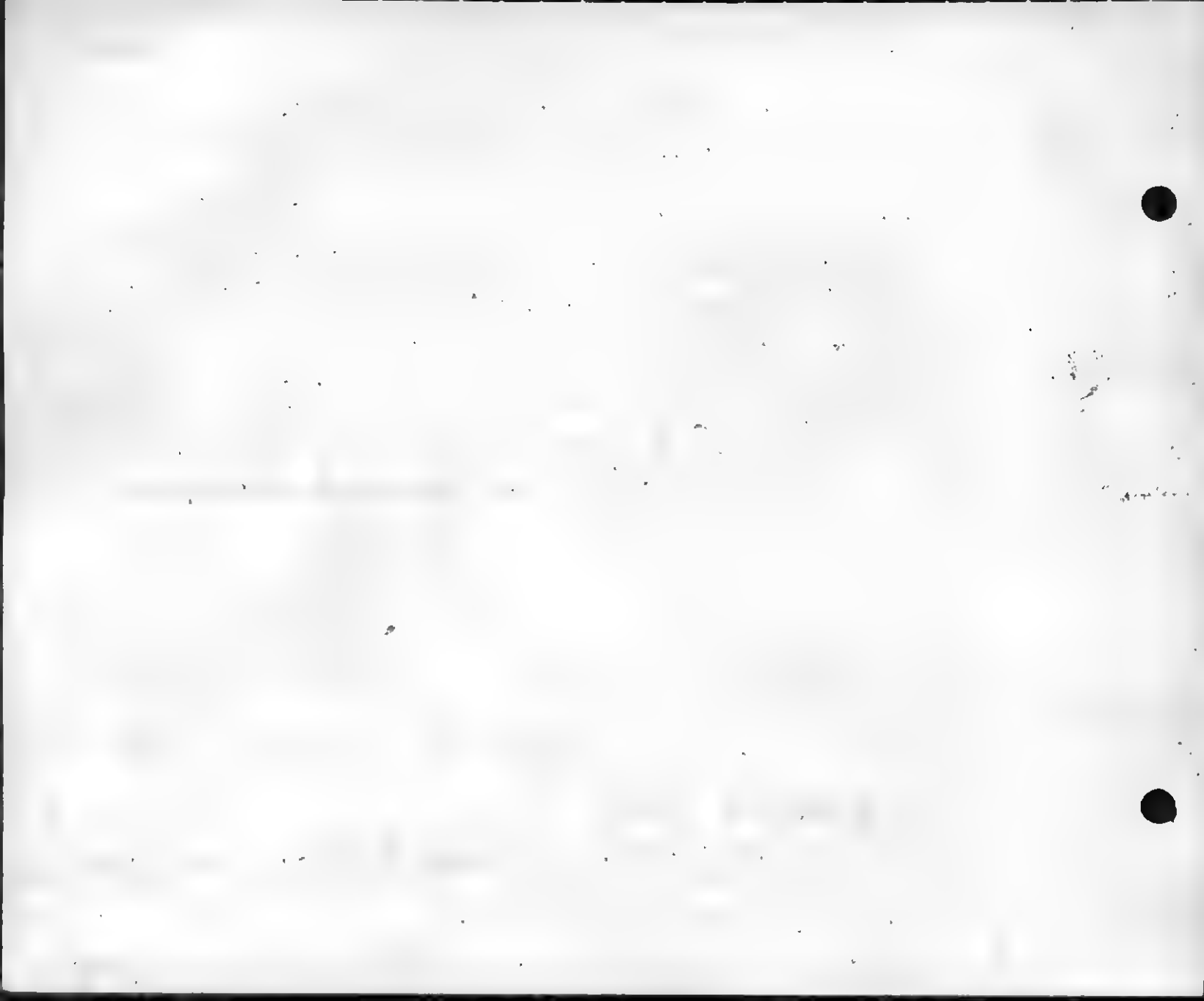


Dr. Kee, coroner, consulted & has released Perez to body - Certificate to be signed by Dr. Kee

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)		First DiCarlo,		Middle Joseph		Last A.		2a. DATE OF DEATH Month 3 Day 1968		2b. HOUR 1:50am
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH 6-26-24		6. AGE (in years lost birthday) 44 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS M.N.
7a. BIRTHPLACE (State or foreign country) D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md				
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Eugene Leland Memorial		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Foreman PEPCO		12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Prince George		13c. CITY OR TOWN Park College		13d. INSIDE CITY LIM 157 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5807 Bucknell Terrace		
14. FATHER'S NAME First Middle Last James I. DiCarlo		15. MOTHER'S MAIDEN NAME First Middle Last Francis Giuffrida								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address Frances DiCarlo (spouse) & Medical Records						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Subarachnoid Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Rupture Intracranial Aneurysm</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>330x</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 29, 1968</u> to <u>Oct 2, 1968</u> , that (I) (we) lost saw the deceased alive on <u>Oct 2, 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Baltazar E. Perez, M.D.</u>		22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>10305 Folk St. Silver Spring MD</u>		22e. DATE SIGNED <u>Oct 3/68</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Oct 5, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland Pro Geo Md.</u>				
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.				25a. REC'D BY REGISTRAR DATE <u>OCT 7 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>				



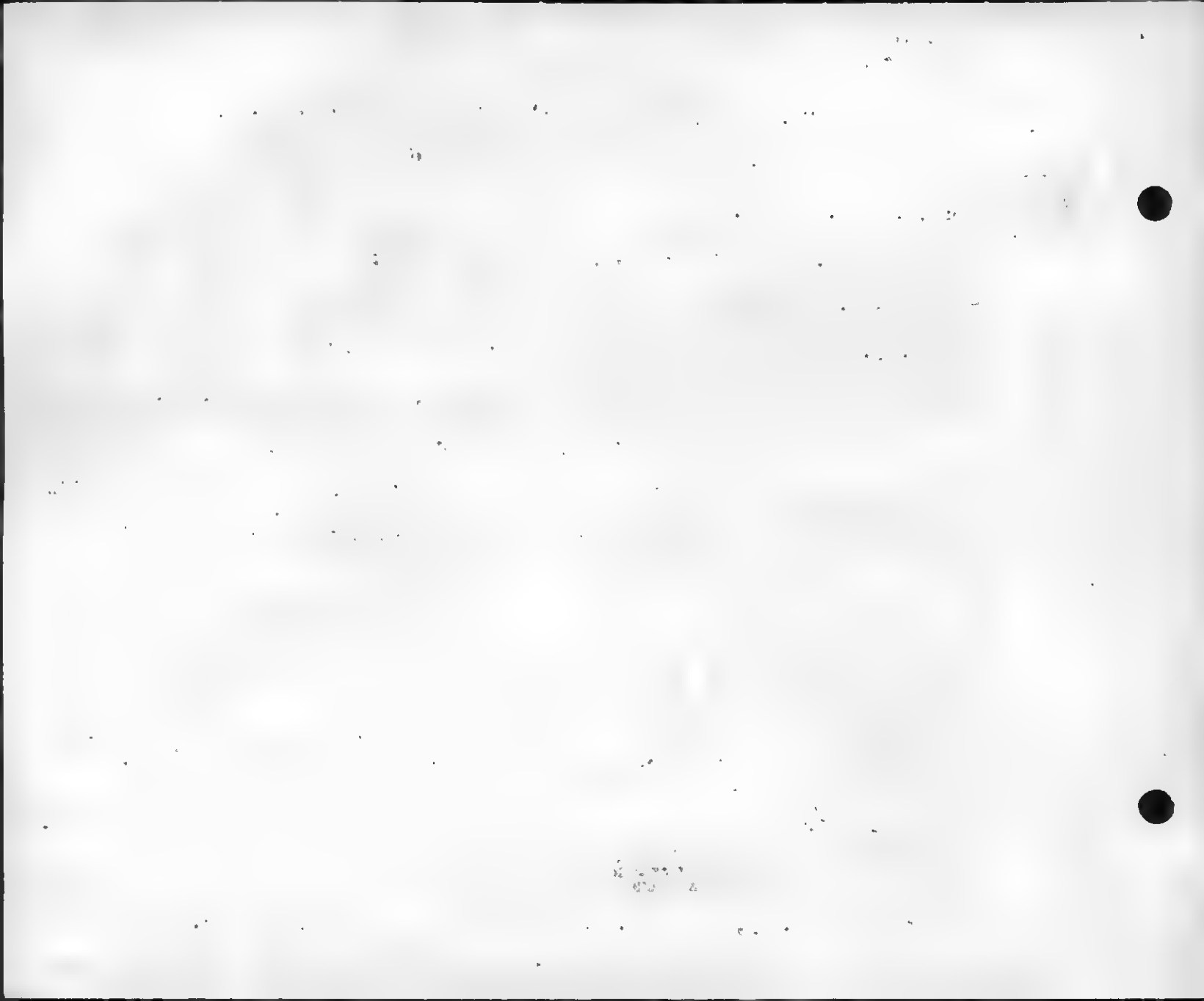


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove, for page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2c. DATE OF DEATH		2b. HOUR	
MALCOLM			DISNEY			Oct. 22, 1968		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male		White		Jan 15, 1989		19 YRS.		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY	
Highland, Md.		U.S.				Prince George		Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Riverdale, Md.		Leland Mem.		Garage owner		Garage			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Highland, Md.		Howard							
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Charles T. Disney			Margaret E. Wilson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
no				Roland L. Disney		Highland, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>coronary occlusion</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>generalized arteriosclerosis</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>4 hours</u> <u>years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4201</u> <u>none</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No		City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>68</u> , to <u>Oct 22</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Oct 22</u> , 19 <u>68</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED							
<u>John R. Buell</u>		<u>Oct 22, 1968</u>							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
JOHN R. BUELL, M.D. 8116 GORMAN AVENUE LAUREL, MARYLAND									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)
Burial		Oct. 23, 1968		Mt. Zion		Highland, Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Donaldson Funeral Home		Laurel, Md.		OCT 28 1968		Charles Judge			



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
10M REV 1/68

14851										14860																																		
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										MEDICAL EXAMINER'S CERTIFICATE OF DEATH																																		
1. DECEASED-NAME (Type or Print)					First Middle Last					2a. DATE KNOWN OF EST. DEATH MATED					2b. HOUR																													
Mary					Dittman					10-3-68					194:00am M																													
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD					2d. HOUR																											
Female		White		7-29-1922		46 YRS.						10 3 68 17:45am M																																
7a. BIRTH-PLACE (State or foreign country)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH																													
Va					U S A										Prince George's Md																													
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)					12b. KIND OF BUSINESS OR INDUSTRY																													
Cheverly					Prince George Hospital					Housewife					Home																													
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER																								
Maryland					Prince George's Maryland Park										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					103 66th. Street																								
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME					16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16b. SOCIAL SECURITY NO.					17. INFORMANT					ADDRESS																			
William M Sudduth					Rose A Dowson					no										Roy N Curtis Maryland Park, Md.																								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rupture of spleen</u> DUE TO, OR AS A CONSEQUENCE OF <u>Splenomegaly</u> (b) <u>From portal hypertension</u> DUE TO, OR AS A CONSEQUENCE OF <u>Cirrhosis of liver</u> (c) _____																																												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																												
19a. DATE OF OPERATION															19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH															21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK															21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)										21f. LOCATION Street or R.F.D. No City or Town County State																			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																																												
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.															22b. DATE SIGNED <u>10-3-68</u>																													
EXAMINER'S NAME (Type) <u>John Kehoe MD Riverdale, Md.</u>															DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>										ADDRESS (Street, city, town, or county)																			
23a. BURIAL, CREMATION, REMOVAL (Specify)															23b. DATE										23c. NAME OF CEMETERY OR CREMATOR										23d. LOCATION (City or Town) (County) (State)									
Burial															Oct 7, 1968										Washington National										Suitland Pro Geo Md.									
24. FUNERAL DIRECTOR															F. Gasch's Sons Hyattsville, Md.										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE									
																									OCT 8 1968										<u>Charles Judge</u>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14852

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14861

1. DECEASED NAME (Type or print) First Middle Last Mary A. Donath			2a. DATE OF DEATH Month Day Year October 5, 1968			2b. HOUR 7:10 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 7/6/81		6. AGE (In years last birthday) 87 YRS.	
7a. BIRTHPLACE (State or foreign country) Wash. DC.		7b. CITIZEN OF WHAT COUNTRY? USA		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.	
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) Prince George's Gen.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired		12b. KIND OF BUSINESS OR INDUSTRY GPO	
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Maryland		13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Landover Hills		13e. STREET AND NUMBER 4204 72nd Avenue	
14. FATHER'S NAME First Middle Last John R. Hutchison			15. MOTHER'S MAIDEN NAME First Middle Last Mary Shuchan				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) none		17. INFORMANT Ann Wetzstein		Address same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Myocardial infarct</u> <u>1109</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>advanced arteriosclerotic and -clerotic disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>15 hr</u>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>CAUSE OF THE THROAT</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (the hospital) attended the deceased from <u>Oct. 1, 1968</u> , to <u>October 5, 1968</u> , that (I) (we) last saw the deceased alive on <u>October 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (didn't) view the body after death.							
22b. SIGNATURE <u>Philip J. Lilly</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>10.5.68</u>	
22d. PHYSICIAN'S NAME (Type) P. J. Lilly M.D.				22e. ADDRESS 4410 74th Ave. Landover Hills, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/8/1968		23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		23d. LOCATION (City or Town) (County) (State) Washington DC.	
24. FUNERAL DIRECTOR Wally's funeral home				ADDRESS Mt Rainier, Md.		25a. REC'D BY REGISTRAR OCT 11 1968	
				25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
14853 CERTIFICATE OF DEATH 14862

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HYATTSVILLE MD. c. LENGTH OF STAY IN ID MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) CARROLL MANOR 4922 LA SALLE RD.				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE DISTRICT of COLUMBIA b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) WASHINGTON, D.C. d. STREET ADDRESS 2222 EYE ST. N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) ALMA M. DORSEY		4. DATE OF DEATH Oct 1 1968		5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-28-1885		9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales lady				10b. KIND OF BUSINESS OR INDUSTRY DEPT. STORE				11. BIRTHPLACE (County & State, or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? US.							
13. FATHER'S NAME GEORGE R. BREWER				14. MOTHER'S MAIDEN NAME JULIA M. WATHEN				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 579-10-1222				17. INFORMANT MARGARET M. DORSEY 2 A & C, d, e ABOVE			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 4120 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic and Hypertensive Heart Disease DUE TO (c) Arteriosclerosis, general PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Post-status: multiple pulmonary emboli												INTERVAL BETWEEN ONSET AND DEATH Years Years Years							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (was hospital) attended the deceased from April 17, 1967, to Oct 1, 1968, that (I) (was) last saw the deceased alive on Dec 30 1968, and that death occurred at 9:20 PM, from the causes and on the date stated above.																			
22a. SIGNATURE John F. Brennan, Jr.				22b. DATE SIGNED Oct 1, 1968				22c. PHYSICIAN'S NAME (Type) JOHN F. BRENNAN, JR.				22d. ADDRESS 3344 RUNNYMEADE PL. N.W., WASHINGTON DC							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 4 Oct. 1968				23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY				23d. LOCATION (City, town or county) (State) WASHINGTON DC.							
24. FUNERAL DIRECTOR R. Ward Funeral Home, Inc. 7400 GEORGIA AVE. N.W.				25a. REC'D BY REGISTRAR OCT 3 1968				25b. REGISTRAR'S SIGNATURE J. Charles Judge											





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

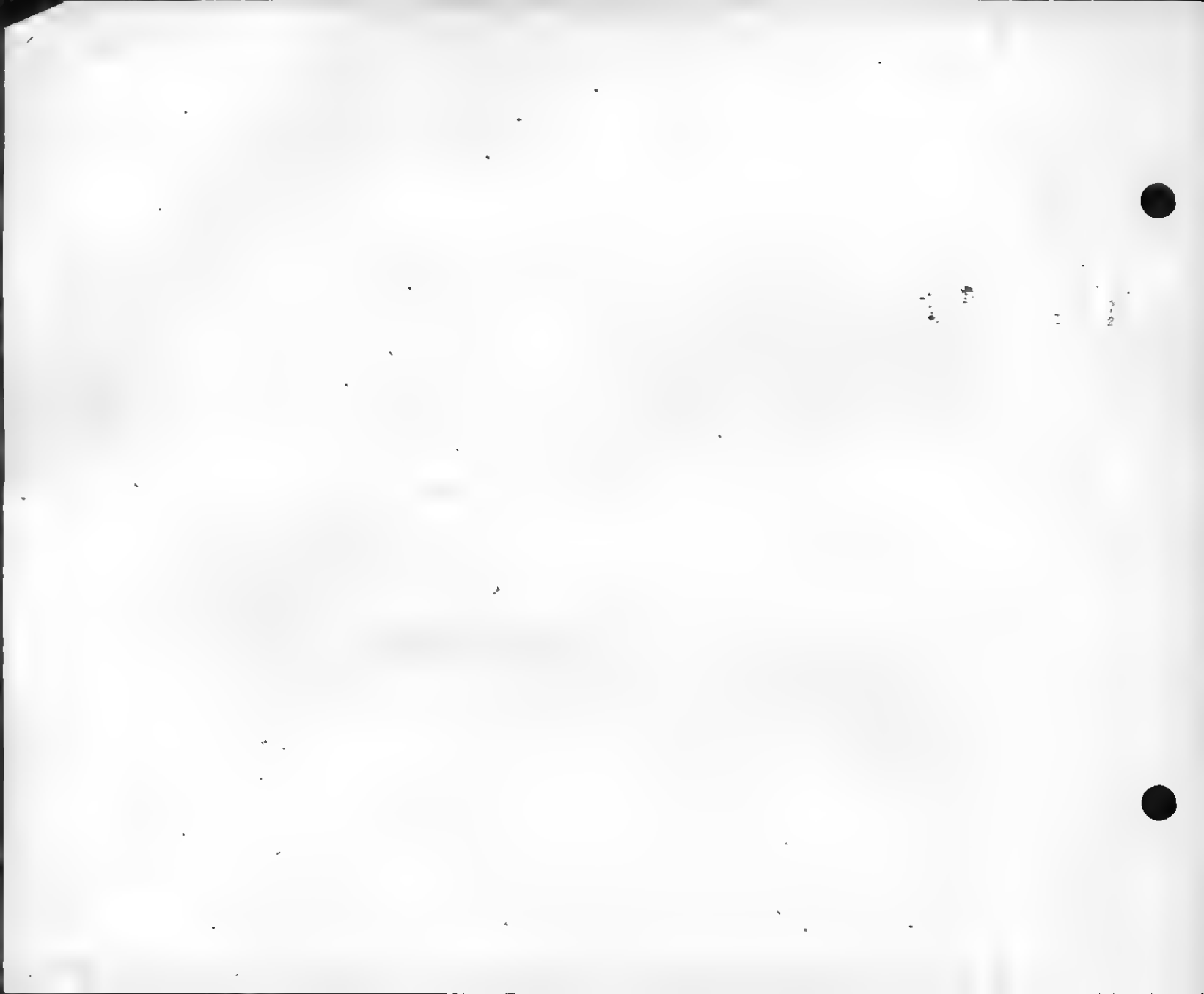
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14854

14863

1. DECEASED NAME (Type or print) <b>ROBERT E. DOVE</b>			2a. DATE OF DEATH Month <b>OCT</b> Day <b>7</b> Year <b>1968</b>			2b. HOUR <b>1:30 P.M.</b>	
3. SEX <b>MALE</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>19 OCT. 1884</b>		6. AGE (In years last birthday) <b>78</b> YRS	
7a. BIRTHPLACE (State or fore'gn country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>PR. GEORGE'S</b>	
10. CITY OR TOWN OF DEATH <b>HYATTSVILLE</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>3911 QUEENSBURY</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>PLUMBER</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>MD</b>		13b. COUNTY <b>PR. GEO.</b>		13c. CITY OR TOWN <b>HYATTSVILLE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>3911 QUEENSBURY RD</b>		14. FATHER'S NAME First Middle Last <b>ROBERT DOVE</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>LOUISA FOUTH</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>578-38-1168</b>		17. INFORMANT <b>WIFE-IVA C. ASHORE</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary emboli</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive pheochromocytoma</b> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Arteriosclerosis, heart disease</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>1958</b> , 19____, to <b>1968</b> , 19____, that (I) (we) last saw the deceased alive on <b>Oct 5, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <b>DR. KE400 NOTIFIED</b>							
22b. SIGNATURE <b>L. L. LEVITSKY</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>10/7/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>L. L. LEVITSKY</b>				22e. ADDRESS <b>MT. RAINIER MD</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>10/10/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL</b>		23d. LOCATION (City or Town) (County) (State) <b>SUITLAND MD.</b>	
24. FUNERAL DIRECTOR <b>F. GASCH'S SONS - Hyattsville, Md.</b>				25a. REC'D BY REGISTRAR <b>OCT 11 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



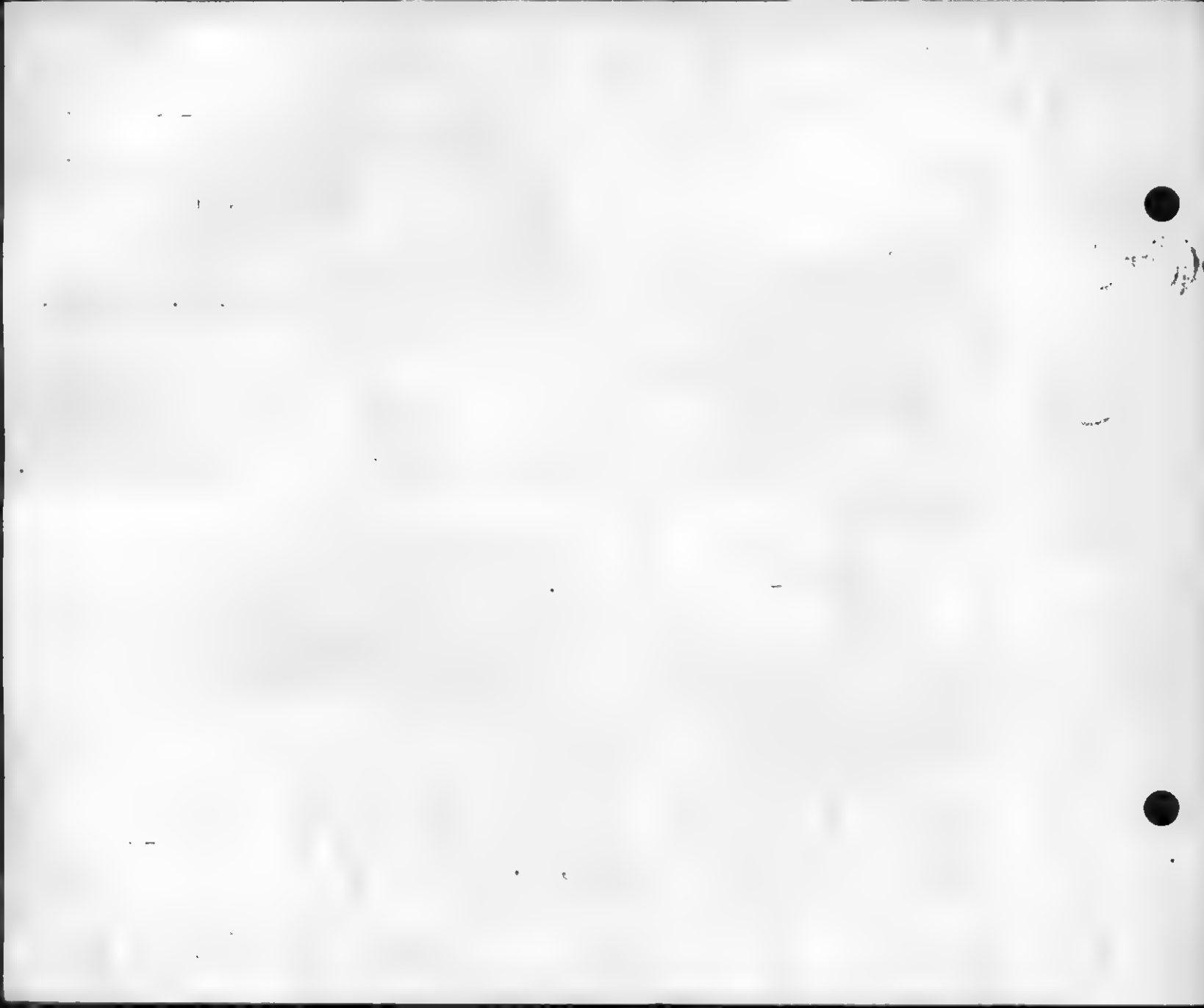
# FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print)										2a DATE KNOWN OF DEATH		2b HOUR					
First			Middle			Last				Month		Day		Year		Hour	
Rebecca			Ethel			Dowell				10-8-68		1911		10pm			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 IF UNDER YEAR		8 IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD		2d HOUR			
Female		Negro		31 June 1906		62 YRS		MONTHS		DAYS		HOURS		MIN.			
7a BIRTHPLACE (State or foreign country)				7b CITIZEN OF WHAT COUNTRY?				8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9 COUNTY OF DEATH					
				U.S.A								Prince George's				Md	
10 CITY OR TOWN OF DEATH						11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)						12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b KIND OF BUSINESS OR INDUSTRY	
Cheverly						Prince George Hospital						None					
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE						13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER					
Maryland						Prince George's		Croom		YES <input type="checkbox"/> NO <input type="checkbox"/>		Box 3333, Mt. Calvert Rd.					
14 FATHER'S NAME						15 MOTHER'S MAIDEN NAME											
James Sims						Laurin Diggs											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16b SOCIAL SECURITY NO.		17 INFORMANT						ADDRESS			
No						None		Regina Washington						SARAH'S 13E.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure														minutes			
DUE TO, OR AS A CONSEQUENCE OF Hypertensive cardio vascular disease														over 14yrs.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost																	
(b)																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
143X Diabetes - known over 14 yrs.																	
19a DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?					
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b TIME OF INJURY Month, Day, Year				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
						HOUR A.M. P.M. 19											
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>						21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)						21f LOCATION Street or R.F.D. No City or Town County State					
22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
22b. DATE SIGNED																	
10-9-68																	
ACTUAL SIGNATURE						CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>											
John Kehoe MD						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
Riverdale, Md.						ADDRESS (Street, city, town or county)											
23a (BURIAL) CREMATION REMOVAL (Specify)						23b DATE		23c NAME OF CEMETERY OR CREMATORY				23d LOCATION (City or Town) (County) (State)					
						10-12-68		St. Marys				Croom Md					
24 FUNERAL DIRECTOR						ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
H.S. Washington & Sons 4925 Deane Ave NE												OCT 17 1968		J. Charles Judge			



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in lines 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1 DECEASED NAME (Type or Print)			First		Middle		Last		2a DATE KNOWN OF DEATH		2b HOUR		
Cecil			M		Downs				Month Day Year		10-20-68 19 8:45am		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c DATE PRONOUNCED DEAD	
Male		White		4-17-1887		81 YRS		MONTHS DAYS HOURS MIN		Month Day Year		10 20 68 19 9:02am M	
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH				
ILLINOIS			U.S.						Prince George's Md.				
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)				12b KIND OF BUSINESS OR INDUSTRY	
Cheverly				Prince George Hospital				CIVIL SERVICE				U.S. Govt	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before address on date of death)				13b CITY				13c INSIDE CITY LIMITS?				13e STREET AND NUMBER	
Maryland				Prince George's				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				12414 Sandle Lane	
14 FATHER'S NAME			First		Middle		Last		15 MOTHER'S MAIDEN NAME			First Middle Last	
William A. Downs									Edith Chester				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS	
No.				302 011626				AUGUST P. BOLTZ.				SAME AS #13	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY.												minutes	
IMMEDIATE CAUSE (a) Heart failure													
DUE TO, OR AS A CONSEQUENCE OF Hypertensive arteriosclerotic heart disease												over 2 yrs.	
(b)													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
443X													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?					
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
CAUSE OF DEATH				P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED					
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				10-21-68					
John Kehoe MD				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county)					
Riverdale, Md.													
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY					
ENTOMBMENT				OCT 24, 1968				MEMORIAL PARK					
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REG STRAR					
W.W. CHAMBERS CO. RIVERDALE, MARYLAND								OCT 30 1968					
								25b. REG STRAR'S SIGNATURE					
								J. Charles Judge					



# FOR STATE HEALTH DEPT.

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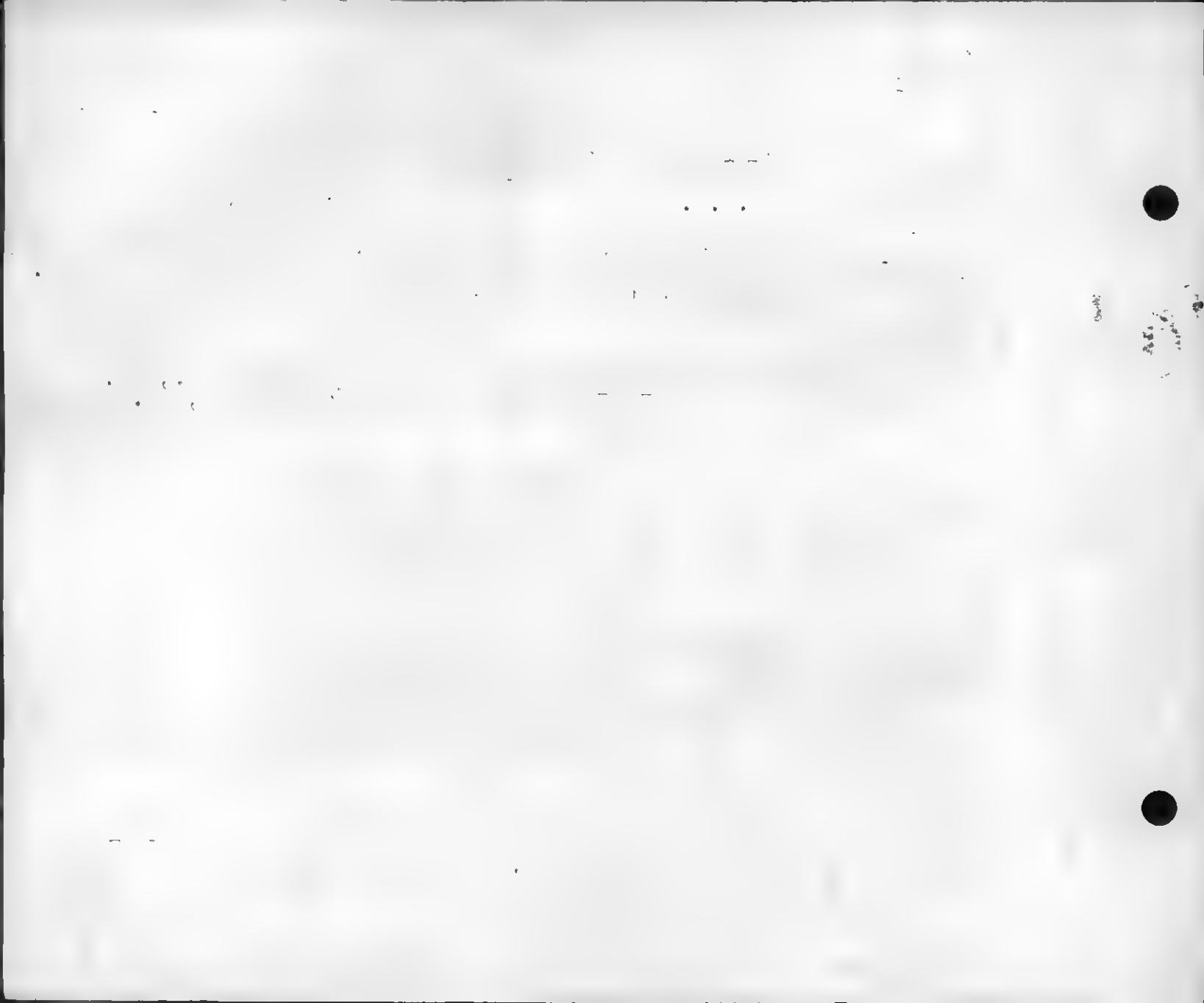
14857

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14866

1 DECEASED NAME (Type or Print) <b>Guy H Duckett</b>			2a DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 10-10-68 1968			2b HOUR 5:00am		
3 SEX <b>Male</b>	4 RACE <b>Negro</b>	5 DATE OF BIRTH <b>12-9-1904</b>	6 AGE (in years last birthday) <b>63</b> YRS	7 UNDER YEAR MONTHS <b>10</b>	8 DAYS <b>10</b>	9 HOURS <b>10</b>	10 MIN <b>10</b>	2c DATE PRONOUNCED DEAD Month Day Year <b>10 10 68</b>
7a BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Prince George's</b> Md		
10 CITY OR TOWN OF DEATH <b>Cheverly</b>			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>Prince George Hospital</b>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Truck Driver</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Commercial Furniture Co.</b>
13a USUAL RESIDENCE (Where deceased lived if institution Residence before) <b>Maryland</b>			13b CITY OR TOWN <b>Prince George's Seat Pleasant</b>			13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <b>7205 F Street</b>
14 FATHER'S NAME <b>Unknown</b>			15 MOTHER'S MAIDEN NAME <b>Jane</b>			16 ADDRESS <b>7205 F St., St. Unknown</b>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16b SOCIAL SECURITY NO <b>577-10-6306</b>			17 INFORMANT <b>Elsie Duckett Pleasant, Md.</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO, OR AS A CONSEQUENCE OF <b>Coronary artery occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) <b>From atherosclerotic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: <b>minutes</b> <b>minutes</b> <b>unknown</b>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4-2-71</b>								
19a. DATE OF OPERATION <b>4-2-71</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f. LOCATION Street or R.F.D. No		City or Town		County State
22a I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <b>John Kehoe MD</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED <b>10-11-68</b>		
EXAMINER'S NAME (Type) <b>John Kehoe MD Riverdale, Md.</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
23a BURIAL, CREMATION, REMOVAL (Specify) <b>10-14-68</b>			23b DATE <b>10-14-68</b>			23c NAME OF CEMETERY OR CREMATORY <b>Lincoln Mem</b>		
24 FUNERAL DIRECTOR <b>Kellins 4339-Hunt PK NE</b>			25a REC'D BY REGISTRAR <b>06114 1968</b>			25b REGISTRAR'S SIGNATURE <b>James Judge</b>		





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

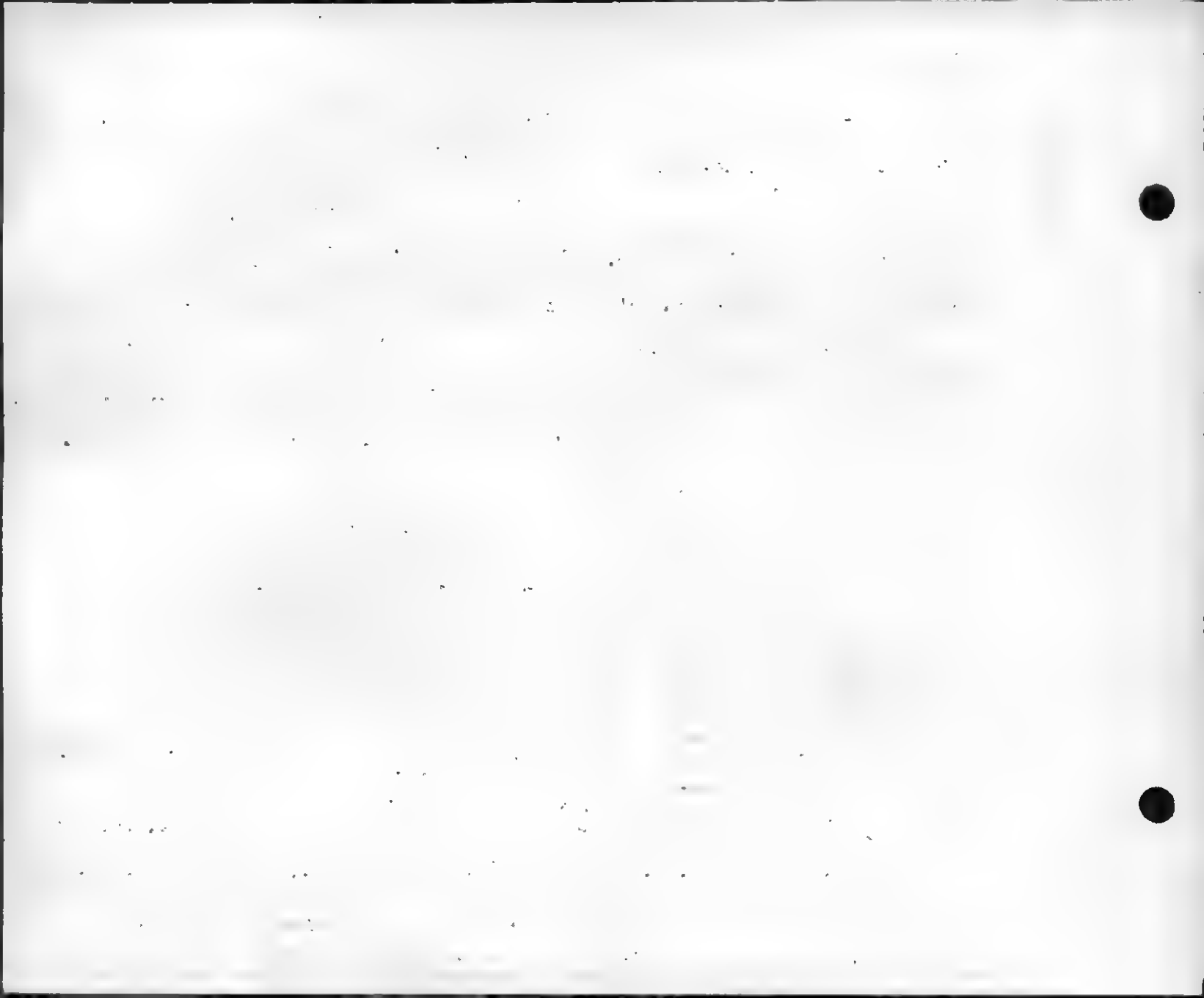
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

14858

14867

1. DECEASED-NAME (Type or print) <b>Virginia R. Duval</b>			2a. DATE OF DEATH Month <b>Oct</b> Day <b>29</b> Year <b>1968</b>			2b. HOUR <b>6 P/M</b>								
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>9-8-1884</b>		6. AGE (In years last birthday) <b>84</b> YRS		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>				
7a. BIRTHPLACE (State or foreign country) <b>Washington</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Prince George's Md.</b>					
10. CITY OR TOWN OF DEATH <b>Cheverly</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo. Gen'l Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Prince George's Seat Pleasant</b>			13c. CITY OR TOWN <b>Seat Pleasant</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>6815 Eads Street</b>		
14. FATHER'S NAME First Middle Last <b>Joseph Palmer</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Mary Steele</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO <b>unknown</b>			17. INFORMANT <b>Nelson Duvall</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO <b>unknown</b>			17. INFORMANT <b>Nelson Duvall</b>			Address <b>3115 Oak Glen Way Forestville, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-vascular accident</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Generalized arteriosclerosis</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Pericardial effusion left lower lobe</b>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State								
22a. I certify that (I) <b>(husband)</b> attended the deceased from <b>January 1968</b> to <b>12-24</b> 19 <b>68</b> , that (I) <b>(we)</b> last saw the deceased alive on <b>12-24</b> 19 <b>68</b> , and that in (my) <b>(we)</b> opinion death occurred on the date and hour and from the causes stated above, (I) <b>(we)</b> (did) <b>(did not)</b> view the body after death.														
22b. SIGNATURE <b>Peter Duus, M.D.</b>			DEGREE <b>M.D.</b>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>Oct. 29, 1968</b>					
22d. PHYSICIAN'S NAME (Type) <b>Peter Duus, M. D.</b>			22e. ADDRESS <b>6056 Central Ave., Capitol Hgts, Md. 20027</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>11-1-68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Congressional</b>			23d. LOCATION (City or Town) (County) (State) <b>Washington, D. C.</b>					
24. FUNERAL DIRECTOR <b>Wilhelm Funeral Home 4308 Suitland Rd. S. E.</b>			ADDRESS			25a. REC'D BY REGISTRAR DATE <b>NOV 6 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

MEDICAL CERTIFICATION



**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-60. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER:

VR A15ME (5)  
10M REV 1/68

<div style="display: flex; justify-content: space-between;"> <span>14859</span> <span>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>14868</span> </div>													
1 DECEASED NAME (Type or Print)			First		Middle		Last		2a DATE KNOWN OF DEATH		2b HOUR		
Hazel			LOVELESS				EARLY		<input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input checked="" type="checkbox"/> 10-7-68 14:30 PM		<input type="checkbox"/> 10-7-68 14:30 PM		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 UNDER 1 YEAR	7 UNDER 24 HRS	2c DATE PRONOUNCED DEAD		2d HOUR					
Female	White	2-3-1910	58 YRS	MONTHS	DAYS	HOURS	MIN	10	Day	68	19	5:20 PM	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH							
MARYLAND		U.S.A.				Prince George's							
10a CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b KIND OF BUSINESS OR INDUSTRY	
Cheverly				Prince George Hospital				ASST. CASHIER				BANK	
13a USUAL RESIDENCE (Where deceased lived, if not in hospital give street address)				13b CITY OR TOWN		13c INSIDE CITY LIMITS?		13e STREET AND NUMBER					
Maryland				Prince George's		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Rt. 4, Box 142A					
14 FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME			First Middle Last	
SAMUEL			O.		LOVELESS				MARY			E. BADEN	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
NO				214-36-3047		ROLAND EARLY, BRANDYWINE, MD.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Laceration of brain													
DUE TO, OR AS A CONSEQUENCE OF Compound skull fracture of skull													
(b) From trauma - auto accident													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?					
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
CAUSE OF DEATH		4:42 PM 10-7-1968		Involved in auto accident.									
21d INJURY OCCURRED		21e PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f LOCATION Street or R.F.D. No. City or Town County State									
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		Rt. 301 and Rt. 381,		Prince George County, Maryland									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED					
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				10-8-68					
John Kehoe MD				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county)					
Riverdale, Md.													
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY				23d LOCATION (City or Town) (County) (State)					
BURIAL		10-11-68		FT. LINCOLN Cem.				BLADENSBURG, MD.					
24. FUNERAL DIRECTOR				25a REC'D BY REGISTRAR				25b REGISTRAR'S SIGNATURE					
HUNT FUNERAL HOME, WALDORF, MD.				OCT 14 1968				Charles Judge					



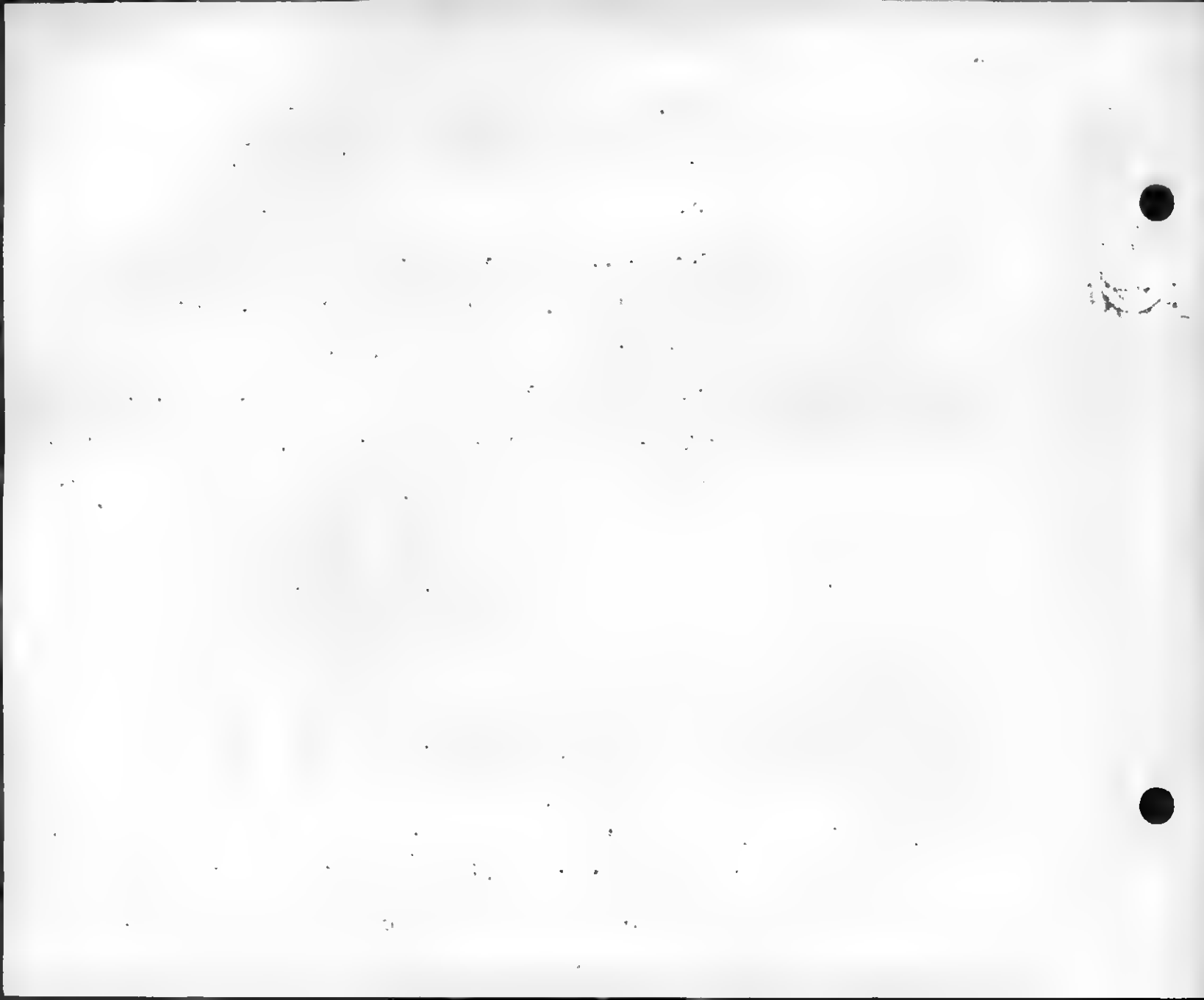
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15 (1)  
30M REV. 7-68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or print) <i>Clara</i>			First <i>M</i> Middle <i>E</i> Last <i>Erhart</i>			2a DATE OF DEATH Month <i>Oct.</i> Day <i>10</i> Year <i>68</i>		2b HOUR <i>9:10 P.</i>		
3. SEX <b>Female</b>			4 RACE <b>Caucasian</b>			5 DATE OF BIRTH <i>Aug. 16, 1882</i>		6 AGE (In years last birthday) <i>86</i> YRS.		
7a. BIRTHPLACE (State or foreign country) <i>New York</i>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Prince George's</b> Md.		
10 CITY OR TOWN OF DEATH <b>Cheverly</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo. Gen'l Hospital</b>			12a USUA. OCCUPATION (Kind of work done during most of working life, even if retired) <i>housewife</i>		12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Maryland</b>			13b COUNTY <b>Prince George's</b>			13c CITY OR TOWN <b>Mt. Rainier</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME First <i>Fred</i> Middle <i>Kitner</i> Last <i>Riley</i>			15. MOTHER'S MAIDEN NAME First <i>Margaret</i> Middle <i>Riley</i> Last <i>Riley</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes, give war or dates of service) <i>None</i>			16b SOCIAL SECURITY NO <i>216 22 0716</i>			17. INFORMANT Address <i>Dorothy Carr 4234 34th St Mt. Rainier</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Rt. Cerebral Vascular Accident</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Severe, Generalized Arterio-sclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs.</i> <i>5 yrs.</i>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Hypertensive Cardio-Vascular Disease</i>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) <del>the hospital</del> attended the deceased from <i>Sept 5, 1968</i> , to <i>Oct 10, 1968</i> , that (I) <del>(we)</del> last saw the deceased alive on <i>Oct 10</i> 1968, and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death.										
22b SIGNATURE <i>Charles C. Hageage</i> M.D.						22c DATE SIGNED <i>Oct 10, 1968</i>		22d. ADDRESS <i>3308 Perry St. Mt. Rainier, Md.</i>		
23a. BURIAL, CREMATON, REMOVAL <i>burial</i>			23b. DATE <i>10/14/1968</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Port Lincoln Cemetery Colmar Manor, Md.</i>			23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR ADDRESS <i>Nalley's Funeral Home Mt. Rainier, Md.</i>						25a. REC'D BY REGISTRAR DATE <i>OCT 15 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

MEDICAL CERTIFICATE ON

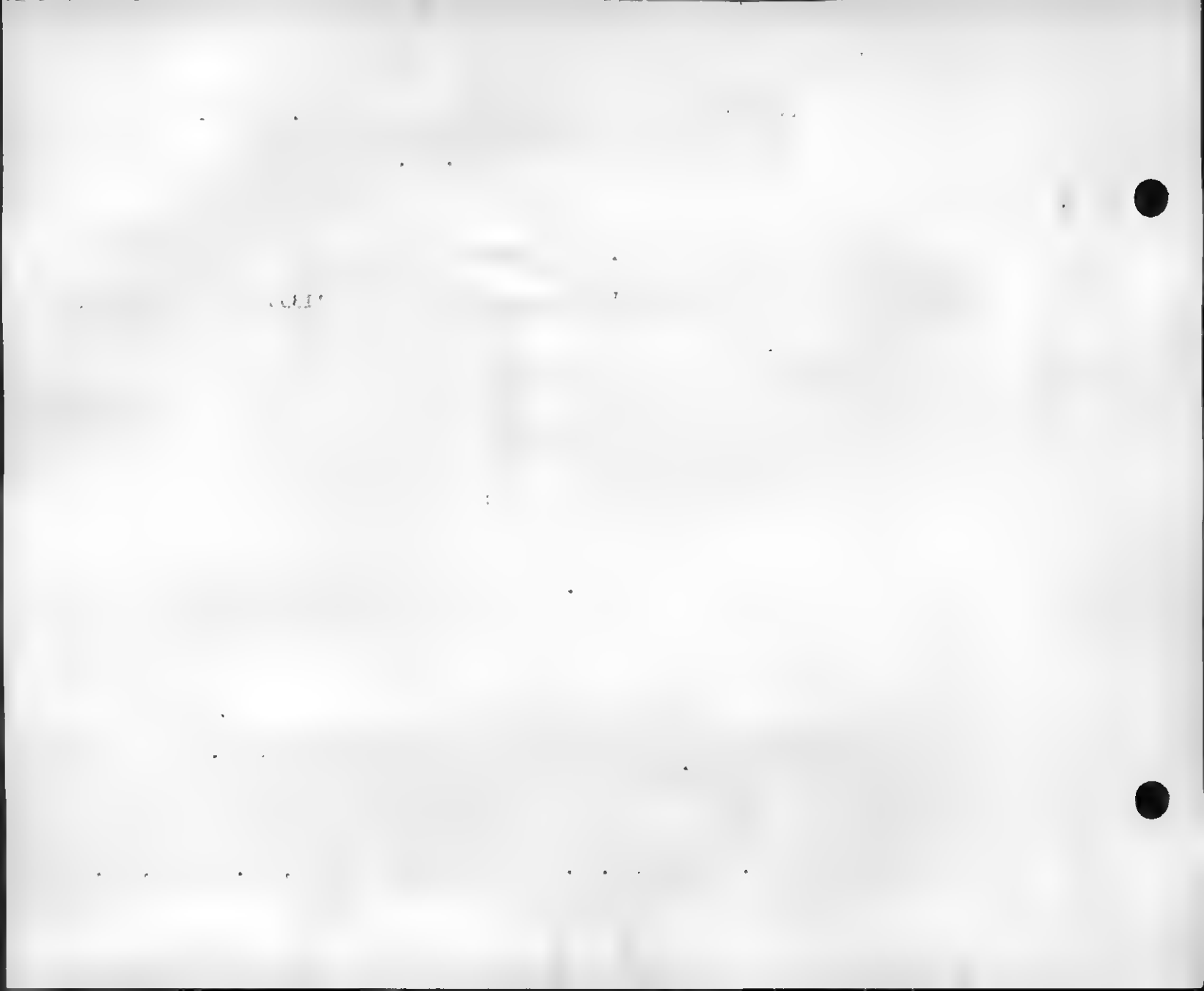


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VR A15  
45M 1/69

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH		
Josephine			Farrell				Oct.		Month 31, Day 1968 Year		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		2b. HOUR		
Female		Caucasian		Nov. 17, 1902			65		1:30AM		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Wash DC		USA				Prince George's Md					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Cheverly			Prince Geo. Gen'l Hdsptal			housewife		home			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Prince George's		Beltsville		YES <input type="checkbox"/> NO <input type="checkbox"/>		11353 Edmonston Avenue		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
John Hunt			Margaret Farrell								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address						
no					Barbara Prince Beltsville Md						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>HYPOGLYCEMIC SHOCK</u>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) <u>DIABETES MELLITUS: TREATED WITH INSULIN</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
(A) HYPERTENSION: (B) OBESITY.											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) <u>Charles C. Hageage</u> attended the deceased from <u>Sept. 7</u> , 19 <u>68</u> , to <u>Oct. 31</u> , 19 <u>68</u> , that (I) <u>xxx</u> last saw the deceased alive on <u>Oct. 31</u> , 19 <u>68</u> , and that in (my) <u>xxx</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>xxx</u> (did) <u>xxx</u> view the body after death.											
22b. SIGNATURE <u>Charles C. Hageage M.D.</u> DEGREE						ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>11/1/68</u>			
22d. PHYSICIAN'S NAME (Type) <u>Charles C. Hageage, M. D.</u>						22e. ADDRESS <u>3308 Perry Street, Mt. Rainier, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE <u>Nov 4, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Ignace</u>		23d. COAT ON (City or Town) (County) (State) <u>Beltsville Prince George's Md</u>				
24. FUNERAL DIRECTOR <u>Donald J. H</u>			ADDRESS <u>Beltsville, Md.</u>			25a. REC'D BY REGISTRAR DATE <u>NOV 8 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. J.</u>			

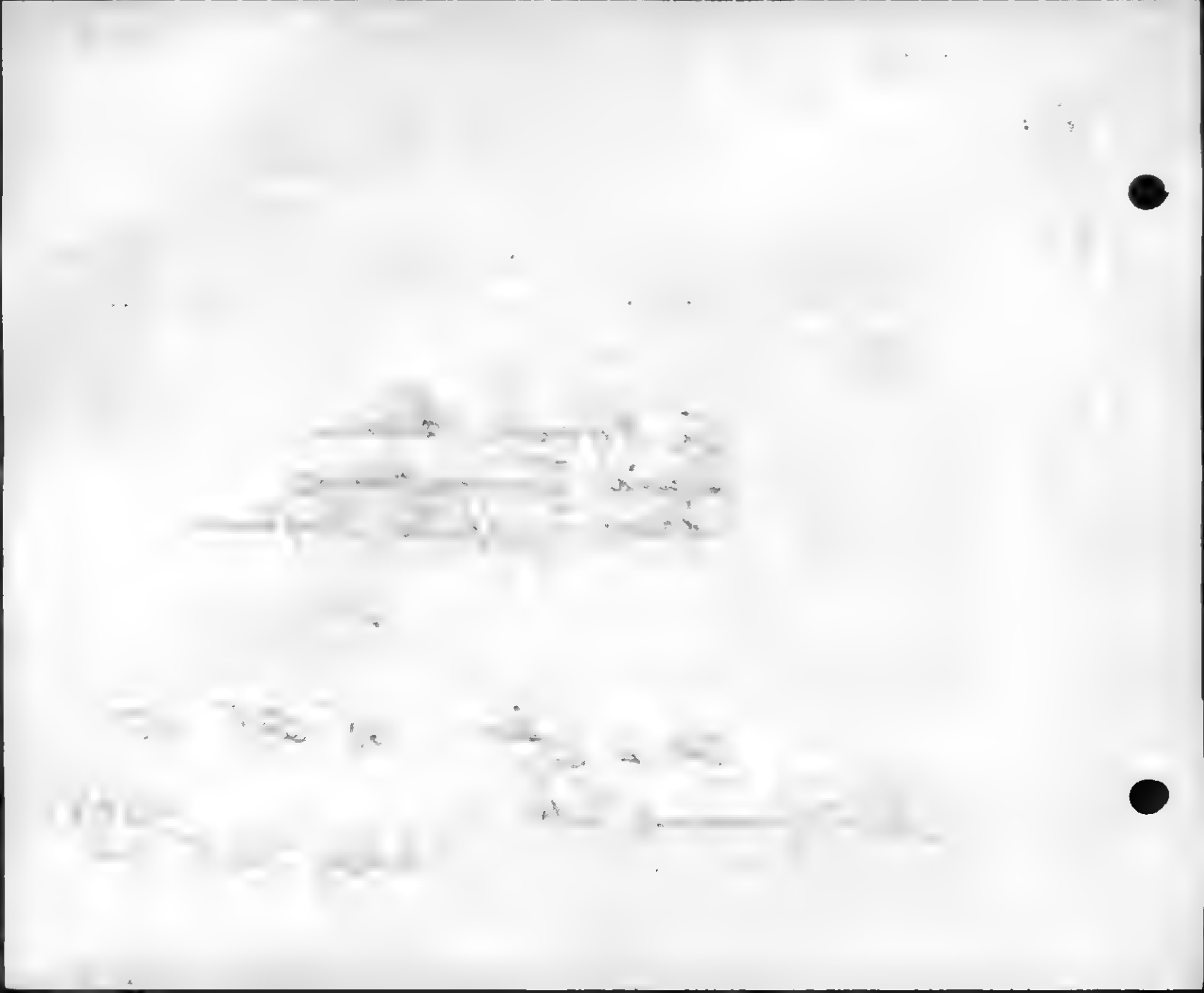




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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 7a Film G406 11/11/68		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		14871	
14862		Item 6 Film G406 11/11/68		CERTIFICATE OF DEATH	
1. DECEASED NAME (Type or print) First Middle Last Harry J. Feaster		2a. DATE OF DEATH Month Day Year 10 24 68		2b. HOUR 7:45 AM	
3 SEX Male		4 RACE White		5. DATE OF BIRTH 10-17-04	
7a. BIRTHPLACE (State or foreign country) Wash, D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (In years last birthday) 66 YRS	
7c. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George Md.			
10. CITY OR TOWN OF DEATH College Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 3423 Metzgerott Rd.,		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Painter	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Pr. Geo.		13c. CITY OR TOWN College Park	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3423 Metzgerott Rd.,			
14. FATHER'S NAME First Middle Last Bentley Feaster		15. MOTHER'S MAIDEN NAME First Middle Last Ruth Whiting			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO 072 14 5957		17. INFORMANT Address Patients former record in Medical Record	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) (b) (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE W. Etienne, M.D.		22c. PHYSICIAN'S NAME (Type)		22d. DATE SIGNED 10/24/68	
22e. ADDRESS College Park, Md.		22f. ADDRESS College Park, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Oct 26, 1968		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery	
23d. LOCATION (City or Town) (County) (State) College Park Pro Geo Md.		24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.			
25a. REC'D BY REGISTRAR DATE OCT 28 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 11-1-68  
304 REV. 1-68

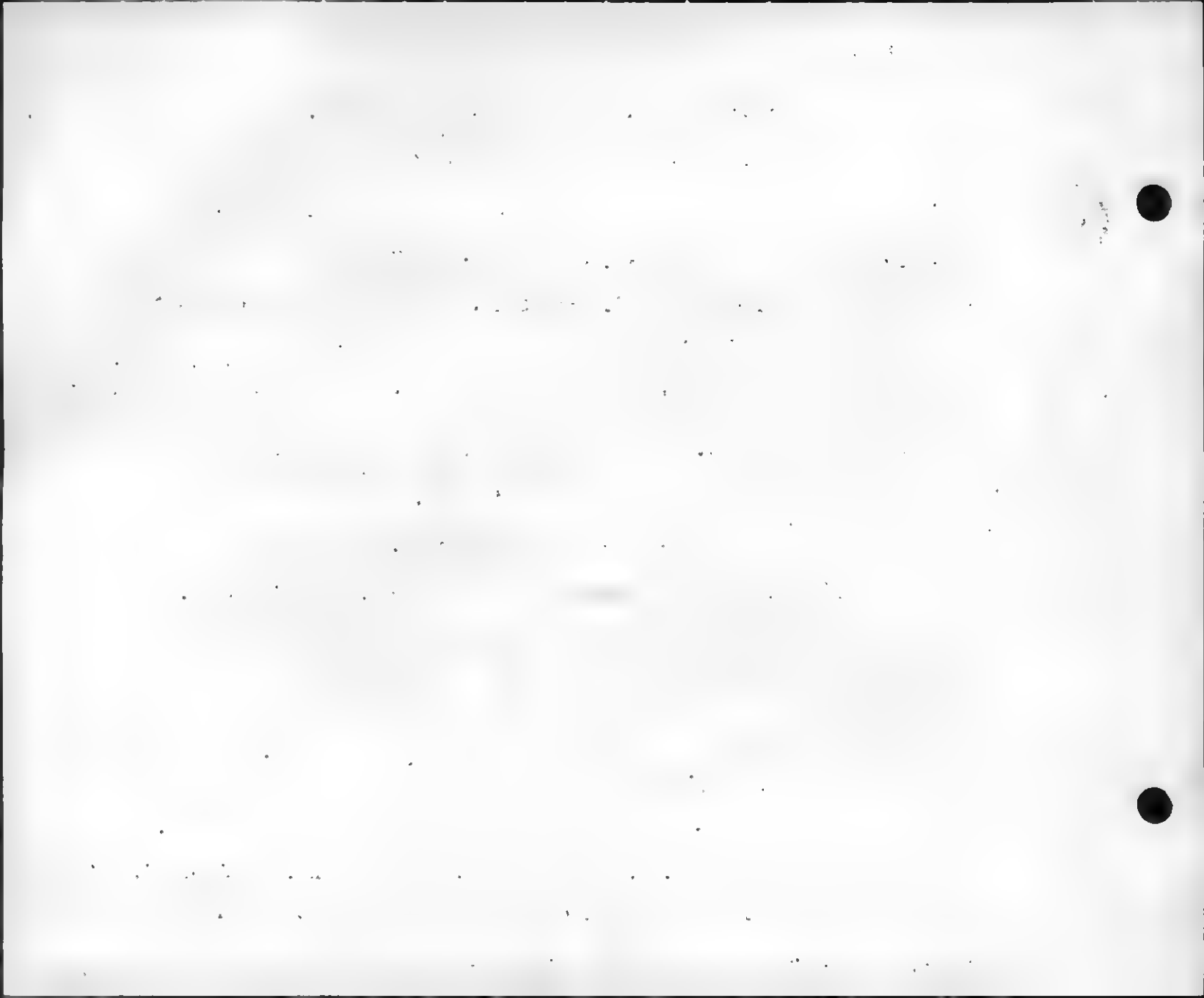
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14863

Item 6 Film 105-1677-28 JK  
CERTIFICATE OF DEATH

14872

1 DECEASED NAME (Type or print) First Middle Last <b>Charles W. Ferguson</b>			2a DATE OF DEATH Month Day Year <b>Oct. 8, 1968</b>		2b HOUR <b>8 A.M.</b>
3 SEX <b>Male</b>	4 RACE <b>Caucasian</b>	5. DATE OF BIRTH <b>1-24-87</b>		6 AGE (In years last birthday) <b>74 81 YRS.</b>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN IF UNDER 24 HRS
7a BIRTHPLACE (State or foreign country) <b>West Virginia</b>	7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <b>Prince George's Md</b>		
10 CITY OR TOWN OF DEATH <b>Cheverly</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo. Gen'l Hospital</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>unlabeled</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Self</b>	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Maryland</b>	13b COUNTY <b>Prince George's</b>	13c CITY OR TOWN <b>Feltsville</b>	13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e STREET AND NUMBER <b>7420 Marlboro Pike</b>	
14. FATHER'S NAME First Middle Last <b>Charles Walter Ferguson</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Janette Taylor</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <b>None</b>		16b SOCIAL SECURITY NO <b>579167329J</b>	17 INFORMANT <b>Margaret Moran</b> Address <b>11719 Black Road Feltsville, Maryland</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Ruptured artiosclerotic aneurysm of the aortic arch with massive hemorrhage into the left lung.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) <b>Generalized arteriosclerosis.</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Chronic passive congestion of liver and abscessed spleen.</b>					
19a DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	20b IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>8-1-1968</b> to <b>Oct. 8, 1968</b> , that (I) <del>(we)</del> saw the deceased alive on <b>Oct. 8, 1968</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) <del>(not)</del> view the body after death.					
22b SIGNATURE <b>Oliver B. Bond</b>			DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c DATE SIGNED <b>Oct. 8, 1968</b>	
22d. PHYSICIAN'S NAME (Type) <b>Oliver Bond, M. D.</b>			22e. ADDRESS <b>6872 Riverdale Rd., Lanham, Md. 20801</b>		
23a BURIAL CREMATION, REMOVAL (Specify)	23b DATE <b>10/11/1968</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Lincoln Cemetery</b>	23d LOCATION (City or Town) (County) (State) <b>Colmar Manor, Maryland</b>		
24. FUNERAL DIRECTOR <b>Nalley's Funeral Home Mt. Rainier, Md.</b>			25a. REC'D BY REGISTRAR DATE <b>OCT 10 1968</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

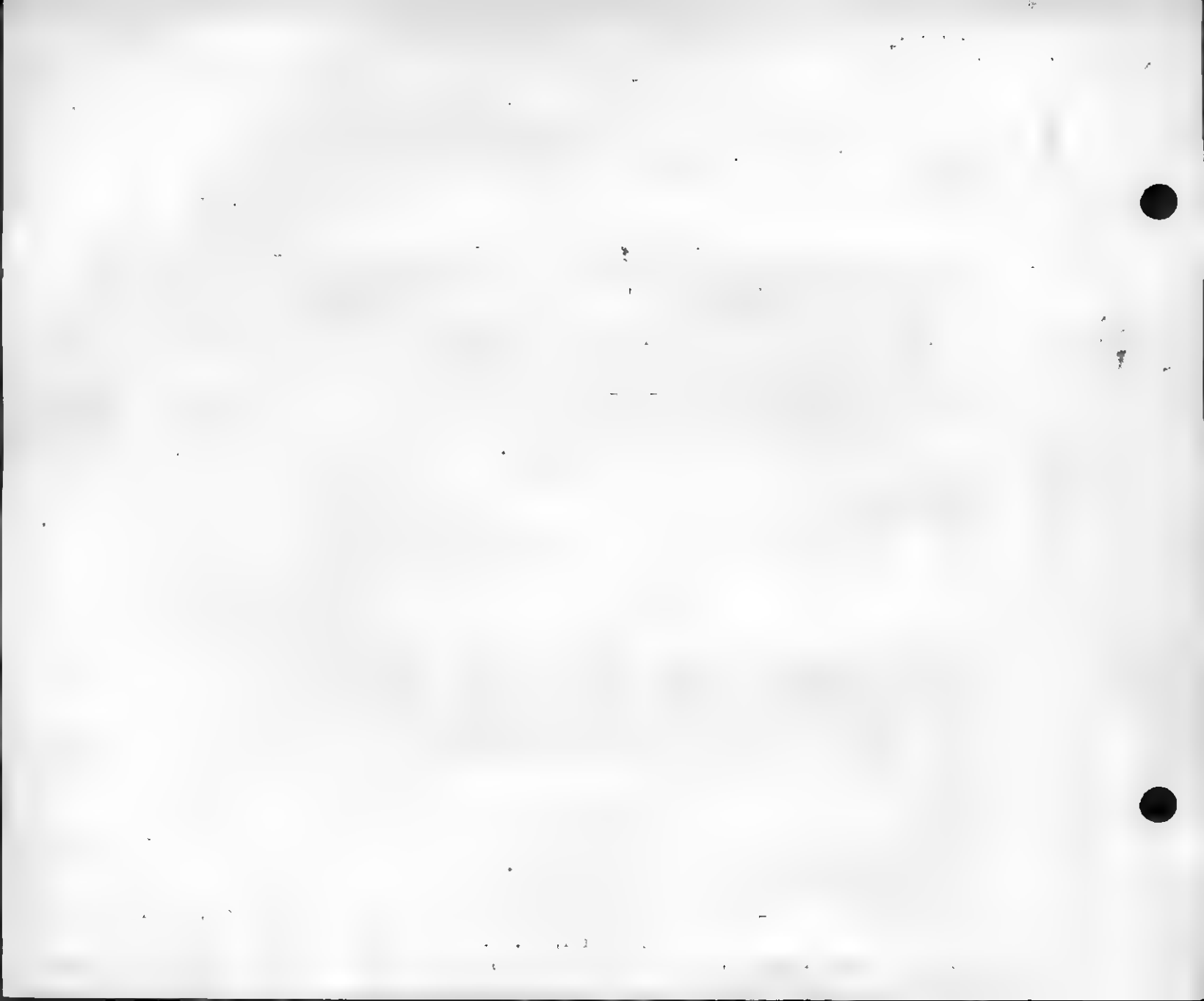


FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH MATED		2b. HOUR		
John Joseph Finegan						10-29-68 19 3:30pm				
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	7. IF UNDER 24 HRS MONTHS	8. IF UNDER 24 HRS DAYS	9. IF UNDER 24 HRS HOURS	10. IF UNDER 24 HRS MIN	2c. DATE PRONOUNCED DEAD		
Male	White	7-8-1918	50 YRS					10 29 68 19 3:30pm M		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH				
Pennsylvania		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Prince George's Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George Hospital			Investigaor - US Army		Governmen		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Prince George's		Bowie		YES <input type="checkbox"/> NO <input type="checkbox"/>		12319 Manship Lane	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
Thomas Finagan			Catherine UNK.			unk				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT ADDRESS					
Yes			WW II		181-09-8608 Hosp. Records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Liver failure fr. Fatty metamorphosis of liver								days		
DUE TO, OR AS A CONSEQUENCE OF (b) and Acute and chronic pancreatitis								days and yrs.		
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
5810										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED				
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			10-30-68				
John Kehoe MD			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial			11-2-68		Holy Sepulchre Cemetery		Wyndmoor, Pennsylvania			
24. FUNERAL DIRECTOR			WASHINGTON, D.C.			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Rinaldi Funeral Home, 7400 Georgia Ave, NW			DATE NOV 1 1968			f Charles Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First MARY Middle R Last FORD			2a. DATE OF DEATH			2b. HOUR
						10 Month 26 Day 68 Year			8 P M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
FEMALE		COLORED		5/14/94		74 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		US				PRINCE GEORGES Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
CLINTON			CLINTON COMMUNITY HOSP			None			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
MD			C. H. ABLES			YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
			Prince Georges Indian Head					105 Woodland Rd	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Unknown			Mary Bean						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			
No			218-07-6647D			Address 105 Woodland Rd			
						Mary R. Bean-Daughter Indian Head, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Cardiac Arrest									
4129 DUE TO, OR AS A CONSEQUENCE OF									
Congestive Heart Failure									
DUE TO, OR AS A CONSEQUENCE OF									
Arteriosclerotic Cardiovascular Disease									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
Coronary									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		HOUR A.M. Month Day Year							
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION					
While <input type="checkbox"/> Not while <input type="checkbox"/> at work				Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 11/11/65, to Death 19, that (I) (we) last saw the deceased alive on Oct 26 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE						22c. DATE SIGNED			
Robert W. Merkle						10/26/1968			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS			
ROBERT W. MERKLE						Clinton, Maryland			
23a. BURIAL, CREMATION, OR OTHER DISPOSAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		10/30/1968		Sacred Heart Cemetery		La Plata, Maryland			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
ARCHART Funeral Home				La Plata, Md.		NOV 4 1968		Charles Judge	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 be retained by the hospital or attending physician. Page 5 be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

1  
14866  
14875  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

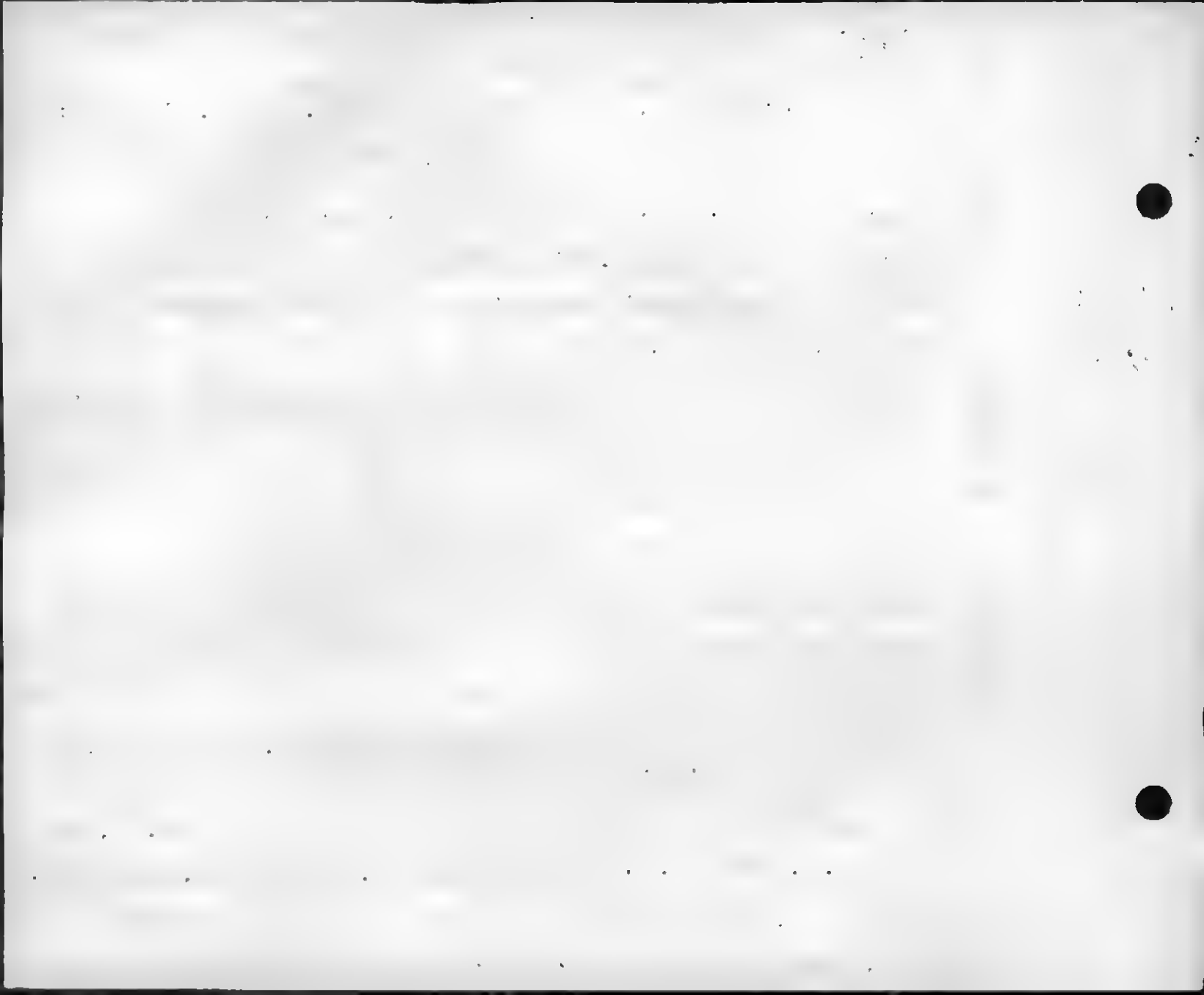
1. PLACE OF DEATH a. COUNTY <u>Prince George</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Accokeek</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Accokeek</u> d. STREET ADDRESS <u>114 Accokeek Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Leona</u> First <u>Laura</u> Middle <u>Frazier</u> Last		4. DATE OF DEATH Month <u>10</u> Day <u>6</u> Year <u>19 68</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>C</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 23, 1905</u>	
9. AGE (In years last birthday) <u>63</u> yrs		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>19</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. BIRTHPLACE (County & State, or foreign country) <u>Norfolk Co. Virginia</u>	
13. FATHER'S NAME <u>James Y. Cuffee</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Faulk</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>579-52-7865</u>	
17. INFORMANT <u>Mrs. Celestine Baskerville</u>		Address <u>114 Accokeek Rd. Accokeek, Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> <u>4360</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>General Arteriosclerosis</u> (a), stating the underlying cause last. (c) <u>Hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <u>12 hrs.</u> years years		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u> years years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) ( <u>hospital</u> ) attended the deceased from <u>9-30</u> to <u>10-4</u> , 19 <u>68</u> that (I) ( <u>no</u> ) last saw the deceased alive on <u>10-1</u> , 19 <u>68</u> , and that death occurred at <u>A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Paul Chen</u> 22c. PHYSICIAN'S NAME (Type) <u>Paul Chen, M.D.</u>		22b. DATE SIGNED <u>Accokeek, Maryland 20607</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 10, 1968</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Family Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Cheasapeake, Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert G. Mason Co. Inc. 2500 Nichols Ave</u>		25a. REC'D BY REGISTRAR <u>WASH. DC</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Benjamin F. Galloway Jr.						Oct. Month 26, Day 1968 Year			8:15PM
3 SEX		4. RACE		5 DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER YEAR IF UNDER 24 HRS
Male		Caucasian		May 18, 1912			56 YRS		MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH			12b. KIND OF BUSINESS OR INDUSTRY
North Carolina		U. S. A.				Prince George's			Miller Sales
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Cheverly			Prince Geo. Gen'l Hospital			Salesman			Miller Sales
13a. USJA. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13e. STREET AND NUMBER
Maryland			Prince George's			Hyattsville			5800 15th Place
14 FATHER'S NAME First Middle Last				15 MOTHER'S MAIDEN NAME First Middle Last					
Benjamin F. Galloway, Sr.				Ella McFee					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17 INFORMANT Address			
No						Jackson Funeral Home, Hendersonville N. C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertension</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>METASTATIC CARCINOMA - LUNG. Primary - Skin</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Malnutrition</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Nat wh e <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or RFD No City or Town County State				
22a. I certify that (this hospital) attended the deceased from <u>9/22/68</u> , 19 <u>68</u> , to <u>Oct. 26, 1968</u> , that (we) last saw the deceased alive on <u>Oct. 26, 1968</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did not) view the body after death.									
22b. SIGNATURE <u>P. C. Xavier, M. D.</u>					DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED		
							Oct. 28, 1968		
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
P. C. Xavier, M. D.					Prince Geo. Gen'l Hospital, Cheverly, Md.				
23a. BURIAL, CREMATION, REMOVA. (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial		Nov. 1, 1968		Laurel Hill Cemetery			Candler, North Carolina		
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Howard H. Hubbard 4107 Wilkens Ave. Balto.					OCT 29 1968		<u>Charles Judge</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14868										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										14877																																							
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																							
MOLLY (NMN) GERUS										Oct 14, 1968										M																																							
3. SEX F										4. RACE W										5. DATE OF BIRTH April 22, 1892										6. AGE (In years last birthday) 76 YRS.										IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.										IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.									
7a. BIRTHPLACE (State or foreign country) UKRAINIA										7b. CITIZEN OF WHAT COUNTRY? USA										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH PRINCE GEORGES. Md.																													
10. CITY OR TOWN OF DEATH BEAIR 7 BOWIE										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life or retired.) HOUSEWIFE										12b. KIND OF BUSINESS OR INDUSTRY AT HOME																													
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD.										13b. COUNTY PRINCE GEORGES										13c. CITY OR TOWN BEMIA BOWIE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13d. INSIDE CITY, IN 157										13e. STREET AND NUMBER 12403 MADELEY LANE																			
14. FATHER'S NAME First Middle Last LUCIUS SAGAN										15. MOTHER'S MAIDEN NAME First Middle Last ANNA KURICZKA										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown										16b. SOCIAL SECURITY NO 195-30-1572										17. INFORMANT Address MRS. JACK MERKLE 12403 MADELEY LANE																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1579 Metastatic cancer of liver										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months																																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										(b) Cancer of Pancreas										4 months																																							
										(c)																																																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										157X																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat. while <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from Sept 6th, 1968, to Oct 14th, 1968, that (I) (we) last saw the deceased alive on Sept 16th, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE Leonard P. Appel M.D. DEGREE										22c. DATE SIGNED 10/14/68																																							
22d. PHYSICIAN'S NAME (Type) LEONARD P. APPEL										22e. ADDRESS 3231 Superior Lane, Bowie Md 20715																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE Oct. 18, 1968										23c. NAME OF CEMETERY OR CREMATORY SUTTON HILL CEMETERY										23d. LOCATION (City or Town) (County) (State) WARREN Co. Penna.																													
24. FUNERAL DIRECTOR										ADDRESS										25a. RECD BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																													
Laurel Funeral Home, Laurel, Md. 20810																				DATE OCT 18 1968										J. Charles Judge																													

MEDICAL CERTIFICATION



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1, 2, and 3. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-100. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

VR A15ME (5)  
10M REV. 1/68

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14869

14878

1. DECEASED-NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF DEATH Month Day Year				2b. HOUR	
Isador Ray Gibson						10-29-68 19 3:00am					
3 SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year		2d. HOUR	
Male	White	12-21-1900	67 YRS					10 29 68 19 3:07am M			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Va		U S A				Prince George's Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George Hospital			Retired cabinet maker			U S Govt		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Prince George's			Riverdale				6319 61st. Avenue	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Samuel Gibson						Catherine B Warner					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)			17. INFORMANT			ADDRESS		
no			578 05 3731A			L. May Gibson			Riverdale, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cerebro vascular occlusion DUE TO, OR AS A CONSEQUENCE OF Generalized arteriosclerosis (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH over 3 yrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2.											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED		
John Kehoe			John Kehoe MD			Riverdale, Md.			10-29-68		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR TOMB		23d. LOCATION (City or Town) (County) (State)					
Burial		Oct 31, 1968		George Washington		Hyattsville Pro Geo Md.					
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
F. Gasch's Sons				Hyattsville, Md.				NOV 1 1968		Charles Judge	





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
10M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or Print)			First		Middle		Last		2a DATE KNOWN OF DEATH	
Darlene			M.		Goldsborough				<input checked="" type="checkbox"/> Month Day Year <input type="checkbox"/> ESTI <input type="checkbox"/> MATED <u>10-27-68</u> 194:15am	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD		2d HOUR
Female	White	4-11-1964	4 YRS	MONTHS DAYS		HOURS MIN		Month Day Year <u>10</u> <u>27</u> <u>68</u> 194:15am M		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH				
Maryland		U.S.A.		W-DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Prince George's Md.				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY	
Cheverly			Prince George Hospital			None			None	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before death)			13b CITY OR TOWN			13c INSIDE CITY (If 13b YES)			13d STREET AND NUMBER	
Maryland			Prince George's Seat Pleasant			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			708 Greig Street	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME							
Joseph L. Goldsborough			Willie V. Thurgood							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.			17 INFORMANT			ADDRESS	
No			None			Joseph L. Goldsborough			4608 Lewis Ave. Suitland Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>Septicemia</u>										
DUE TO, OR AS A CONSEQUENCE OF <u>Pseudomonas infection</u>										
(b) <u>From burns of 70% of body surface</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
9/66										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?			
							YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
2a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
CAUSE OF DEATH			12:35pm 9-23-1968			Burned when clothing caught fire from stove.				
21d INJURY OCCURRED			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			Home			same as #13				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED	
John Kehoe			John Kehoe MD Riverdale, Md.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			10-28-68	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)							
23a BURIAL-CREATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)		
Burial			10-30-68		Washington National			Suitland, Maryland		
24 FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
W. W. Chambers Co. 517-11 <sup>th</sup> St. S.E.						NOV 6 1968		J. Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled up by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14871

14880

1. DECEASED-NAME (Type or print) <b>CHARLOTTE A. GORMAN</b>			2a. DATE OF DEATH <b>OCT</b> Month <b>5</b> Day <b>1968</b> Year			2b. HOUR <b>2P.</b> M.			
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>July 8, 1935</b>		6. AGE (In years last birthday) <b>33</b> YRS.		7. UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>	
7a. BIRTHPLACE (State or foreign country) <b>WASHINGTON, DC</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>PRINCE GEORGES</b> Md.			
10. CITY OR TOWN OF DEATH <b>CHEVERLY</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>PRINCE GEORGES</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE <b>MD</b>		13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>BOWIE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>2602 KINDERBROOK</b>	
14. FATHER'S NAME First <b>HOWARD</b> Middle <b>STODGNILL</b> Last <b></b>				15. MOTHER'S MAIDEN NAME First <b>DAISY</b> Middle <b>FEELEY</b> Last <b></b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b>		16b. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT <b>ROBERT J. GORMAN</b>		Address <b>SAME AS #13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA</b> <b>1001</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>LUNG CARCINOMA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> (And trans, if any, which gave rise to immediate cause (a), stating the underlying cause lost.)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 YEAR</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>1 NONE</b>									
19a. DATE OF OPERATION <b>OCT 1967</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CARCINOMA LUNG.</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <b></b> Month <b></b> Day <b></b> Year <b>19</b> P.M. <b></b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. <b></b> City or Town <b></b> County <b></b> State <b></b>					
22a. I certify that (I) (this hospital) attended the deceased from <b>SEPT</b> , 19 <b>67</b> , to <b>OCT 5</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>OCT 3</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Norman K Bohrer MD</b>		DEGREE <b></b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>OCT 5, 1968</b>					
22d. PHYSICIAN'S NAME (Type) <b>NORMAN K. BOHRER MD.</b>		22e. ADDRESS <b>BOWIE MARYLAND</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>10-8-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GATE 4 HEAVEN CEM</b>		23d. LOCATION (City or Town) (County) (State) <b>WHEATON, MARYLAND</b>			
24. FUNERAL DIRECTOR <b>WILLIAM CHAMBERS CO.</b>		ADDRESS <b>RIVERDALE, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>OCT 8 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 8. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages read 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
10M REV 1/68

14872

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14881

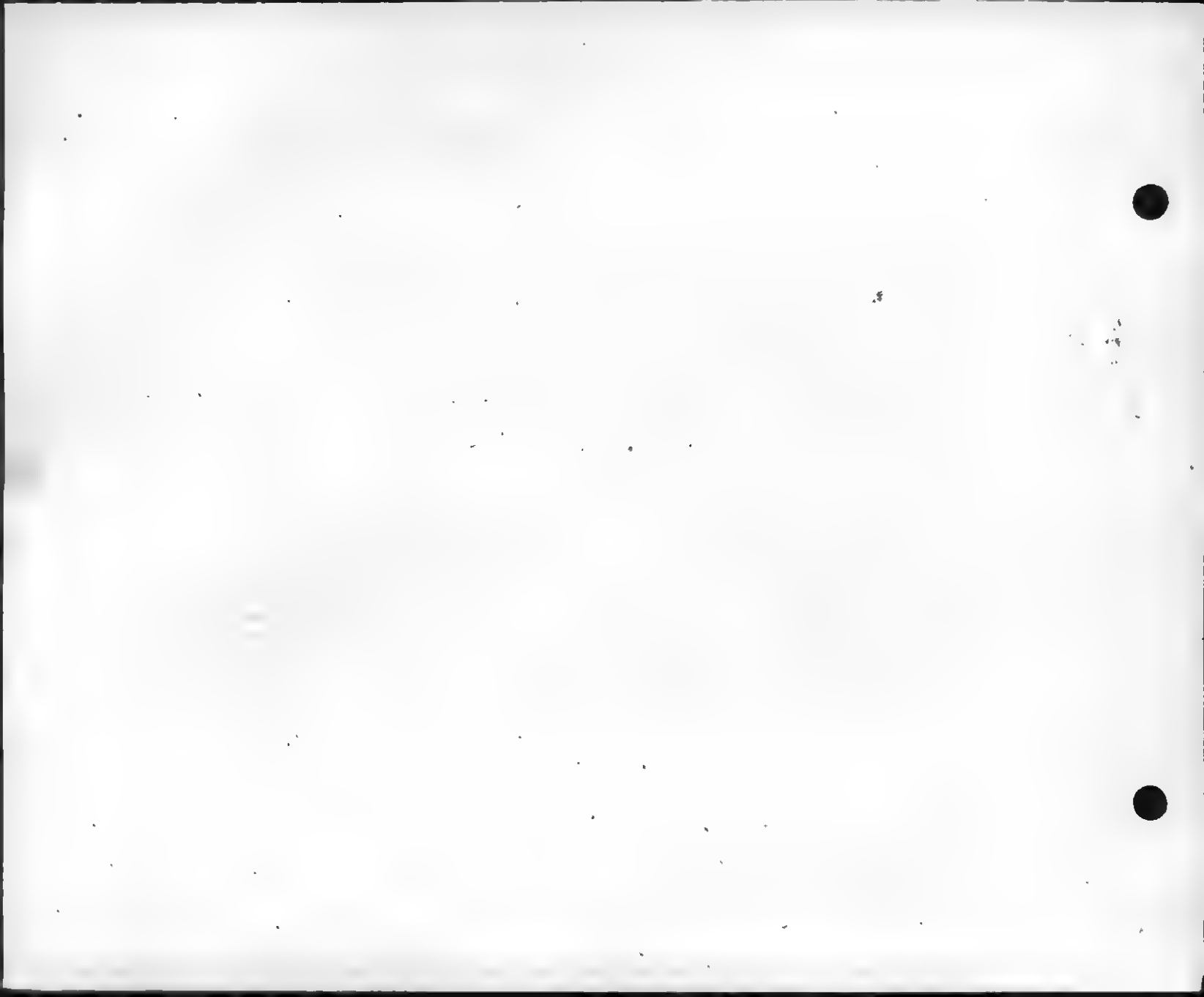
1. DECEASED NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> Month		Day		Year		2b. HOUR	
Thomas		Francis		Gray				10-23-68		17		30		pm		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		Month		Day		Year	
Male	Negro	1-15-1898		70		YRS				10		23		68		1:30pm M	
7a. BIRTHPLACE (State or foreign country)		7b. C.T. ZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH								Md	
Pr. Geo. Md.		U.S.A.						Prince George's									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY											
Cheverly		Prince George Hospital															
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER									
Maryland		Prince George's		Brandywine		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Box 135									
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last			
Isiah						Gray		Frances						Hall			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
				Vincent Gray		Box 135, Brandywine, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))		PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		Arteriosclerotic heart disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		minutes		unknown			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)													
CAUSE OF DEATH		19															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State							
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>																	
22a. I certify that I took charge of the remains described above, held on		Autopsy <input type="checkbox"/>		Inspection <input checked="" type="checkbox"/>		Inquiry <input type="checkbox"/>		and in my opinion death resulted from		Natural causes <input checked="" type="checkbox"/>		Accident <input type="checkbox"/>		Suicide <input type="checkbox"/>		Homicide <input type="checkbox"/>	
Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED		10-24-68					
EXAMINER'S NAME (Type)		John Kehoe MD		Riverdale, Md.		ADDRESS (Street, city, town or county)											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)							
Burial		10-26-68		House of Prayer # 2 Cem.		Brandywine, Pr. Geo. Md.											
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REG STRAR		25b. REG STRAR'S SIGNATURE											
Martell Adams		Aquasco, Md.		OCT 30 1968		Charles Judge											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
Theresa		P.		Griffith				Month 10 Day 26 Year 68		2:30 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years lost birthday)		7. UNDER 1 YEAR		8. UNDER 24 HRS.	
Female		Negro		3-22-1889		79 YRS.		MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Baltimore, Md.		U.S.A.				Prince George's Md.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Upper Marlboro						School Teacher					
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Md.		P. Geo.		Upper Marlboro				Box 3250			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
First Middle Last		First Middle Last									
Edward Pyle		Sarah Ferguson									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT Address							
				Wm. L. Griffith - same as above							
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction											
4109 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic Cardiovascular Disease										Spit	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
42-1											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from May, 1963, to Oct., 1968, that (I) (we) last saw the deceased alive on 10/18/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED									
A. Clark Holmes M.D.		10/26/68									
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
A. Clark Holmes M.D.		14806 Pratt Street Upper Marlboro, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		10-30-68		Mt. Carmel Ch. Cem.		Upper Marlboro P. Geo. Md.					
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Martell Adams		DATE NOV 1 1968		J. Charles Judge							





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-141  
30M REV. 1/68

<div style="display: flex; justify-content: space-between;"> <span>14876</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>14883</span> </div>											
1. DECEASED NAME (Type or print) <u>Laura</u>				First Middle Last <u>Griffiths</u>				2a. DATE OF DEATH Month <u>10</u> Day <u>30</u> Year <u>68</u>			2b. HOUR M
3. SEX <u>Female</u>		4. RACE <u>W</u>		5. DATE OF BIRTH <u>10-31-89</u>			6. AGE (In years last birthday) <u>78</u> YRS.		IF UNDER 1 YEAR MONTHS <u>  </u> DAYS <u>  </u>		IF UNDER 24 HRS. HOURS <u>  </u> MIN <u>  </u>
7a. BIRTHPLACE (State or foreign country) <u>PA</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Prince George</u> Md.					
10. CITY OR TOWN OF DEATH <u>Farmersville</u>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Regent Nursing Home</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Housewife</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <u>MD</u>			13b. COUNTY <u>PG</u>		13c. CITY OR TOWN <u>Marlow Hts.</u>		13d. INSIDE CITY LIM 157 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>5935 23 Place</u>		
14. FATHER'S NAME First <u>WALTER</u> Middle <u>BROWNLEE</u> Last <u>  </u>				15. MOTHER'S MAIDEN NAME First <u>  </u> Middle <u>  </u> Last <u>  </u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no <input checked="" type="checkbox"/> Unknown <input type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO <u>UNKNOWN</u>		17. INFORMANT <u>Laura Comerford, same as #13, (Daughter)</u> Address <u>  </u>						
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Coronary Thrombosis?</u> <u>4109</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>  </u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>  </u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>  </u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <u>  </u> Month <u>  </u> Day <u>  </u> Year <u>19</u> P.M. <u>  </u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION Street or R.F.D. No <u>  </u> City or Town <u>  </u> County <u>  </u> State <u>  </u>							
22a. I certify that (I) (this hospital) attended the deceased from <u>  </u> , 19 <u>  </u> , to <u>  </u> , 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>  </u> , 19 <u>  </u> , and that in (my) (our) opinion, death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <u>See Reverse side</u>											
22b. SIGNATURE <u>J. H. Thibault, M.D.</u> DEGREE <u>  </u> ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>						22c. DATE SIGNED <u>10-30-68</u>					
22d. PHYSICIAN'S NAME (Type) <u>J. H. Thibault, M.D.</u>						22e. ADDRESS <u>3112 AIA Ave. S.E.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>10-25-68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>UNION CEMETERY</u>				23d. LOCATION (City or Town) (County) (State) <u>PECKVILLE, PENNA.</u>			
24. FUNERAL DIRECTOR <u>Wilhelm Funeral Home</u> ADDRESS <u>4308 Suitland Rd. SE, Suitland, Maryland</u>						25a. REC'D BY REGISTRAR DATE <u>OCT 28 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

10 Oct 05 - New road in front of house

at 2nd - 1st - 2nd - 3rd - 4th - 5th - 6th - 7th - 8th - 9th - 10th

at 1st - 2nd - 3rd - 4th - 5th - 6th - 7th - 8th - 9th - 10th

at 1st - 2nd - 3rd - 4th - 5th - 6th - 7th - 8th - 9th - 10th

at 1st - 2nd - 3rd - 4th - 5th - 6th - 7th - 8th - 9th - 10th

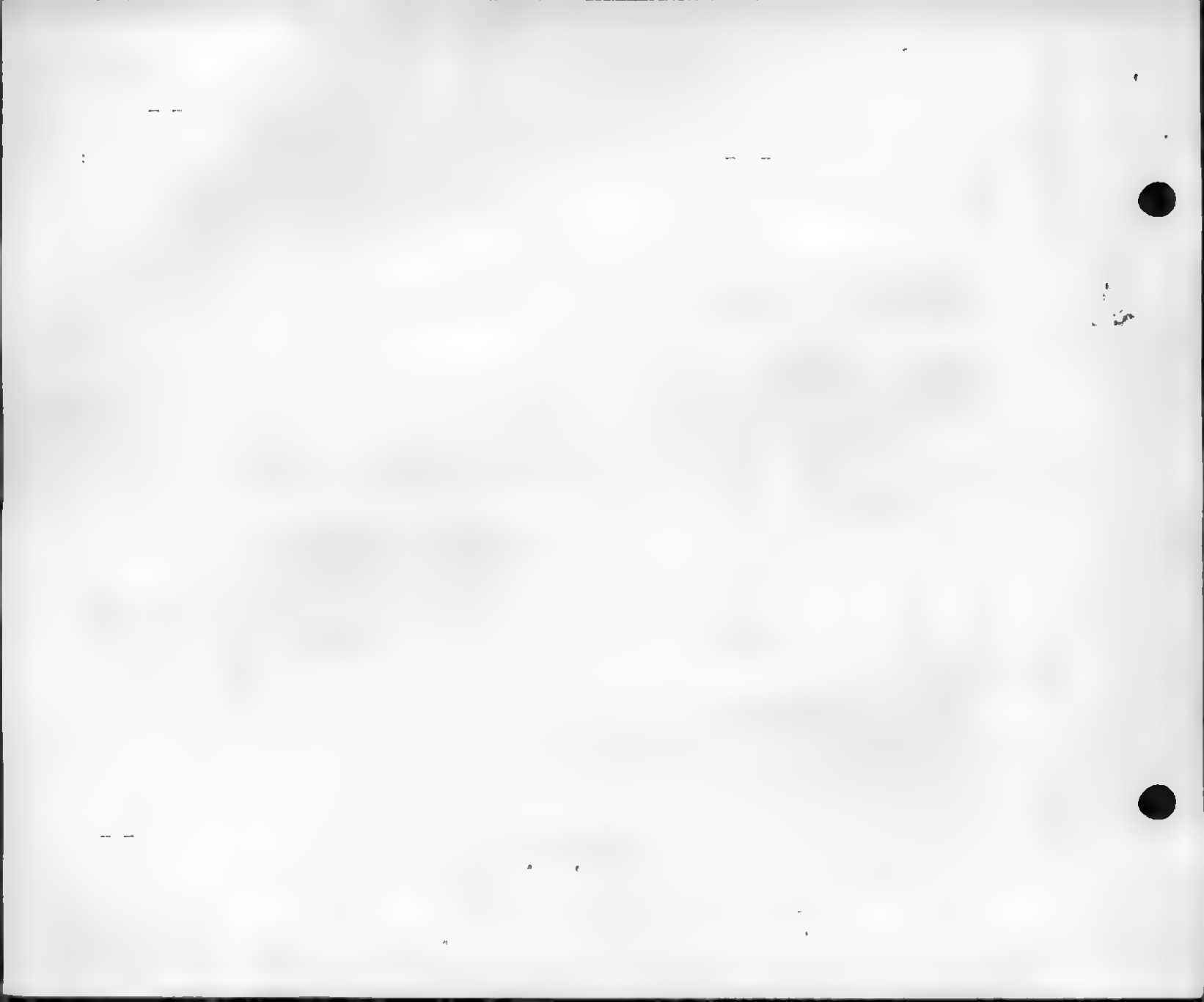
FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. See Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



14875										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										14884																								
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																																												
1. DECEASED NAME (Type or Print)					First Middle Last					2a. DATE KNOWN OF ESTI- DEATH MATED					Month Day Year					2b. HOUR																								
Walter					D					Haight					10-3-68					19 4:30am																								
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)			F UNDER YEAR		IF UNDER 24 HRS			2c. DATE PRONOUNCED DEAD					2d. HOUR																								
Male		White		4-11-1899			69 YRS.			MONTHS DAYS		HOURS MIN.			Month Day Year					68 19 5:17am																								
7a. BIRTHPLACE (State or foreign country)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH																													
Washington, D.C.					U.S.A.										Prince George's Md.																													
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)					12b. KIND OF BUSINESS OR INDUSTRY																													
Cheverly					Prince George Hospital					Sportswriter					Newspapers																													
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)					13b. CITY OR TOWN					13c. HOUSE CITY LIM 15?					13e. STREET AND NUMBER																													
Maryland					Montgomery					Silver Spring					YES <input type="checkbox"/> NO <input type="checkbox"/>					2009 Osborn Drive																								
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME					16a. WAS DECEASED EVER IN U.S. ARMED FORCES?										16b. SOCIAL SECURITY NO.					17. INFORMANT																			
Joe					Haight					Phoebe					Sneeden																													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?					16b. SOCIAL SECURITY NO.					17. INFORMANT										ADDRESS																								
Yes					N.W.I.					Florence E. Haight, wife, same as # 13																																		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary artery occlusion																																												
41																																												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																																												
DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease																																												
(b)																																												
DUE TO, OR AS A CONSEQUENCE OF																																												
(c)																																												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																												
4201																																												
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?																								
																				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																								
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>										21b. TIME OF INJURY Month, Day, Year										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																								
CAUSE OF DEATH										P.M. 19																																		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>										21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)										21f. LOCATION Street or R.F.D. No. City or Town County State																								
AT WORK <input type="checkbox"/>																																												
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural cause <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																																												
22b. DATE SIGNED																																												
10-3-68																																												
ACTUAL SIGNATURE															M.D.																													
EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.															CHIEF MEDICAL EXAMINER <input type="checkbox"/>																													
															ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>																													
															DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>																													
															ADDRESS (Street, city, town, or county)																													
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)														
Burial										10-7-1968										Parklawn Cemetery										Rockville, Montgomery, Md.														
24. FUNERAL DIRECTOR															25a. REC'D BY REGISTRAR															25b. REGISTRAR'S SIGNATURE														
Joseph Gawler's SONS, Inc., 5130 Wisc. Ave. N.W., Washington, D.C., 20016															OCT 7 1968															Charles Judge														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14876										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										14885									
1. DECEASED NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR									
First Middle Last Cicily Ball Haley										Month Day Year October 5 1968										p 2:30 M									
3 SEX Female			4. RACE White			5. DATE OF BIRTH July 4, 1879			6. AGE (In years last birthday) 90 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN														
7a. BIRTHPLACE (State or foreign country) England			7b. CITIZEN OF WHAT COUNTRY? United States			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Prince George Md.																				
10. CITY OR TOWN OF DEATH Hyattsville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Sacred Heart Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY HOME																				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Anne Arundel			13c. CITY OR TOWN Annapolis			13d. INSIDE CITY - YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 96 Gloucester																	
14. FATHER'S NAME First Middle Last George Ball					15. MOTHER'S MAIDEN NAME First Middle Last Mary Taylor																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no			16b. SOCIAL SECURITY NO. 220-05-0496			17. INFORMANT Sacred Heart Home			Address Hyattsville, Maryland																				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease &amp; Congestive heart failure</u> +129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic obstructive pulmonary disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>5 years</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat'wide <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE, BUILDING, ETC.			21f. LOCATION Street or R.F.D. No. City or Town County State																							
22a. I certify that (I) (this hospital) attended the deceased from May 24, 1968, to Oct 3, 1968, that (I) (we) last saw the deceased alive on Oct 3, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE Thomas F Collins								DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED																			
22d. PHYSICIAN'S NAME (Type) THOMAS F COLLINS								22e. ADDRESS 254 - M. AVE																					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 10-8-68			23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l			23d. LOCATION (City or Town) (County) (State) Arlington Va.																				
24. FUNERAL DIRECTOR John M. Taylor Annapolis, Md.								25a. REC'D BY REGISTRAR DATE OCT 9 1968		25b. REGISTRAR'S SIGNATURE Charles Judge																			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) <b>FANNIE L HAMPTON</b>			2a. DATE OF DEATH Month <b>05</b> Day <b>06</b> Year <b>68</b>			2b. HOUR <b>6P</b> M				
3 SEX <b>F</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>4/26/1896</b>		6. AGE (In years last <b>72</b> YRS.)		IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince Georges</b> Md.				
10. CITY OR TOWN OF DEATH <b>Lanham</b>			11. NAME OF HOSPITAL OR INSTITUTION (Not in hospital give street address) <b>Hopkins Nursing Home</b>			12a. USJA. OCCUPATION (Kind of work done during most of work ng life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USJA. RESIDENCE (Where deceased lived, if institution residence before admission) STATE <b>Md</b>			13b. COUNTY <b>Prince Georges</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>11705 Chelworth La.</b>			
14. FATHER'S NAME First <b>Mike</b> Middle <b>Scott</b> Last <b>Scott</b>			15. MOTHER'S MAIDEN NAME First <b>?</b> Middle <b>?</b> Last <b>?</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>no</b> (If yes give war or dates of service)				
16b. SOCIAL SECURITY NO			17. INFORMANT <b>Wm F HAMPTON</b> Address <b>Baltimore, Md 937-7497</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))				
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral Arterio-sclerosis, adv</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arterio-sclerotic Heart Disease</b>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>05/15/68</b> to <b>05/25/68</b> , that (I) (we) last saw the deceased alive on <b>05/25/68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>W L Etienne</b> DEGREE <b>MD</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>10/13/68</b>		22d. PHYSICIAN'S NAME (Type) <b>W L ETIENNE</b> 22e. ADDRESS <b>College Park Md</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>10/27/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Family Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Harrover Co Tenn</b>				
24. FUNERAL DIRECTOR <b>Charles Jones Hyattsville Md</b>		25a. REC'D BY REGISTRAR <b>OCT 28 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>						

MEDICAL CERTIFICATION

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Handwritten text at the top right, possibly a date or reference.

Handwritten text in the upper middle section, appearing to be a list or series of entries.

Handwritten text in the middle section, continuing the list or entries.

Handwritten text in the lower middle section, possibly a summary or conclusion.

Handwritten text at the bottom of the page, possibly a signature or footer.



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pen in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

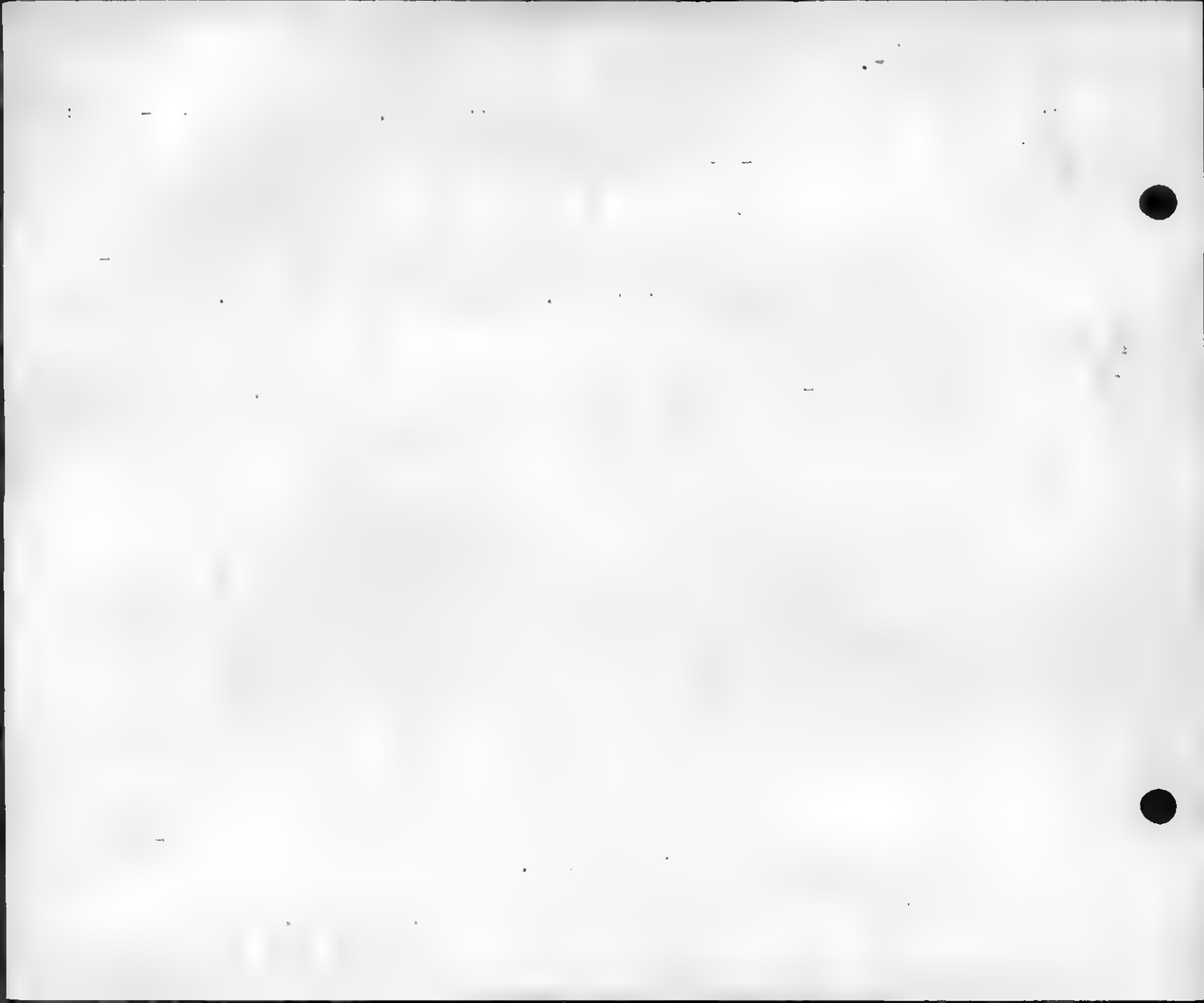
VR A15ME (5)  
10M REV. 1/68

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14878

14887

1 DECEASED NAME (Type or Print) First Middle Last David R Harris Sr.			2a DATE KNOWN OF DEATH Month Day Year 10-21-68 1911			2b HOUR 00am				
3 SEX Male		4 RACE White		5 DATE OF BIRTH 10-15-1903		6 AGE (in years last birthday) 66 YRS		7c DATE PRONOUNCED DEAD Month Day Year 10 21 68 12:15pm		
7a BIRTHPLACE (State or foreign country) North Carolina		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince George's Md				
10 CITY OR TOWN OF DEATH Cheverly			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Equipment Operator			12b KIND OF BUSINESS OR INDUSTRY -	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) Maryland			13b CITY OR TOWN Prince George's			13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13d STREET AND NUMBER 4111 33rd. Street	
14 FATHER'S NAME First Middle Last Joseph Harris			15 MOTHER'S MAIDEN NAME First Middle Last Della Henry							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b SOCIAL SECURITY NO (If yes give war or dates of service) 224-12-9528			17 INFORMANT ADDRESS David R. Harris Jr. (above address)				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive bilateral pulmonary emboli 400A Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) 700										
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No City or Town County State				
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe MD			22b. DATE SIGNED 10-22-68			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 10/25/68		23c. NAME OF CEMETERY OR CREMATORY Congressional Cem.			23d. LOCATION (City or Town) (County) (State) Wash. D.C.		
24 FUNERAL DIRECTOR Name Inc. Valley's Funeral Home Inc.						25a. REC'D BY REGISTRAR DATE OCT 28 1968		25b. REGISTRAR'S SIGNATURE J Charles Judge		



14879

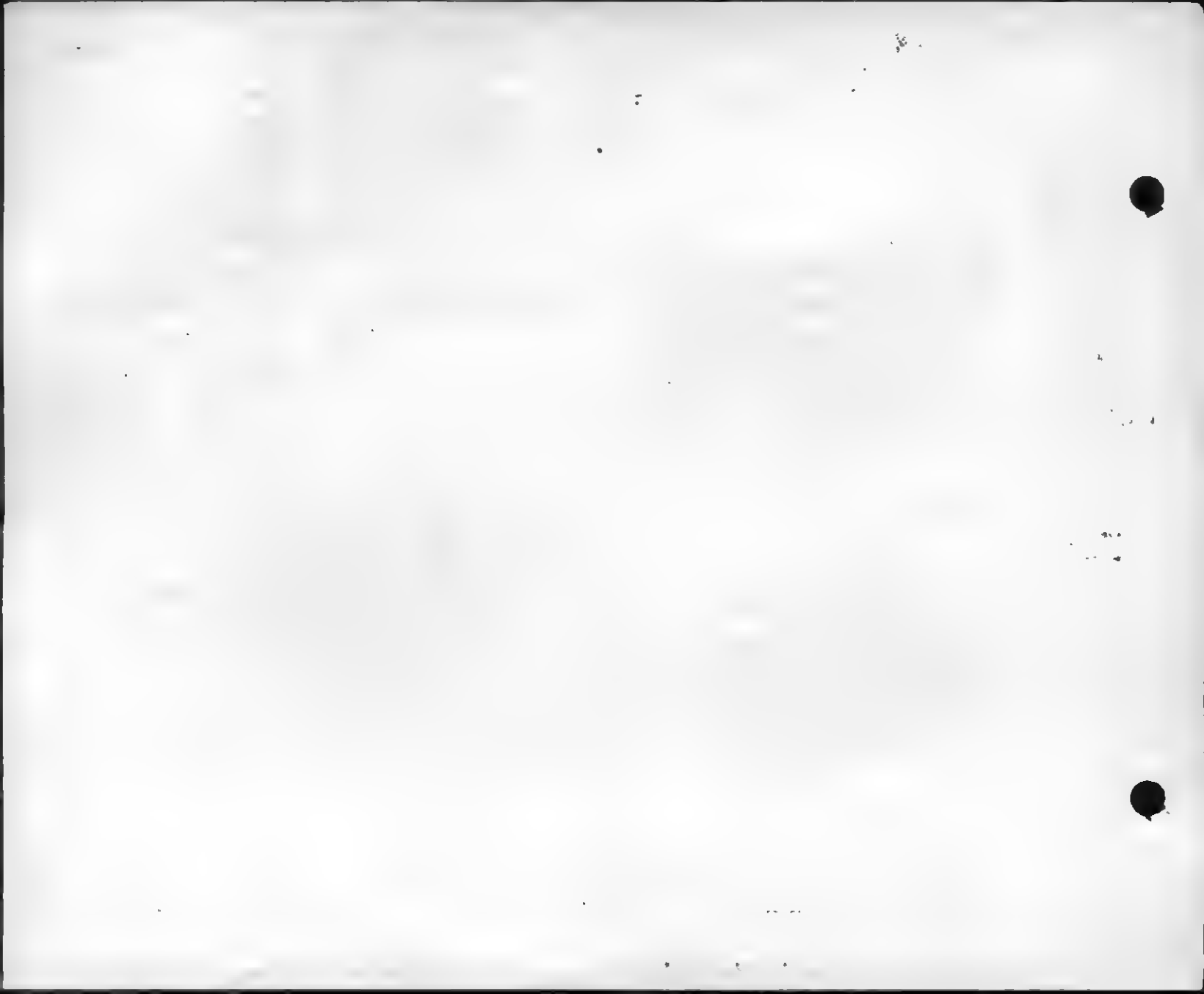
CERTIFICATE OF DEATH

14888

1. DECEASED-NAME (Type or print) <i>MARGUERITE</i>		First Middle Last		2a. DATE OF DEATH Month <i>10</i> - Day <i>3</i> - Year <i>68</i>			2b. HOUR <i>11:55</i> AM	
3. SEX <i>Female</i>		4. RACE <i>Cauc.</i>		5. DATE OF BIRTH <i>11-12-91</i>			6. AGE (In years last birthday) <i>76 7/8</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>New York</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Prince Georges</i> Md.		
10. CITY OR TOWN OF DEATH <i>Forestville</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>The Regent Nursing Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <i>STATE Md. 1000</i>		13b. CITY OR TOWN <i>Prince Georges</i>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>7537 Broadview Rd.</i>		
14. FATHER'S NAME First <i>Earnest F.</i> Middle <i>Weed</i> Last				15. MOTHER'S MAIDEN NAME First <i>Lizzi</i> Middle <i>Sawyer</i> Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <i>Unknown</i>		17. INFORMANT Name <i>Thomas Hazapis, Son Honolulu, Hawaii (USN)</i> Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonitis</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Long Comatose State</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>C.V.A. &amp; Old Hemiparesis</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>6 mo</i> <i>9 mo</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <i>A.S.H.D. &amp; Chronic Cystitis</i>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <i>9/2/68</i> to <i>10/4/68</i> , that (I) (we) last saw the deceased alive on <i>10/4/68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death								
22b. SIGNATURE <i>Kelvin L. Minchin</i>				DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <i>10/4/68</i>		
22d. PHYSICIAN'S NAME (Type) <i>KELVIN L. MINCHIN</i>				22e. ADDRESS <i>64 Marlboro Rd.</i>				
23a. BURIAL, CREMATION, OR OTHER DISPOSITION (Specify) <i>BURIAL</i>		23b. DATE <i>10-7-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Greenridge Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Saratoga Springs, N.Y.</i>		
24. FUNERAL DIRECTOR <i>Wilhelm Funeral Home</i> <i>4308 Suitland Rd. SE, Wash. D.C.</i>				25a. REC'D BY REGISTRAR DATE <i>OCT 8 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

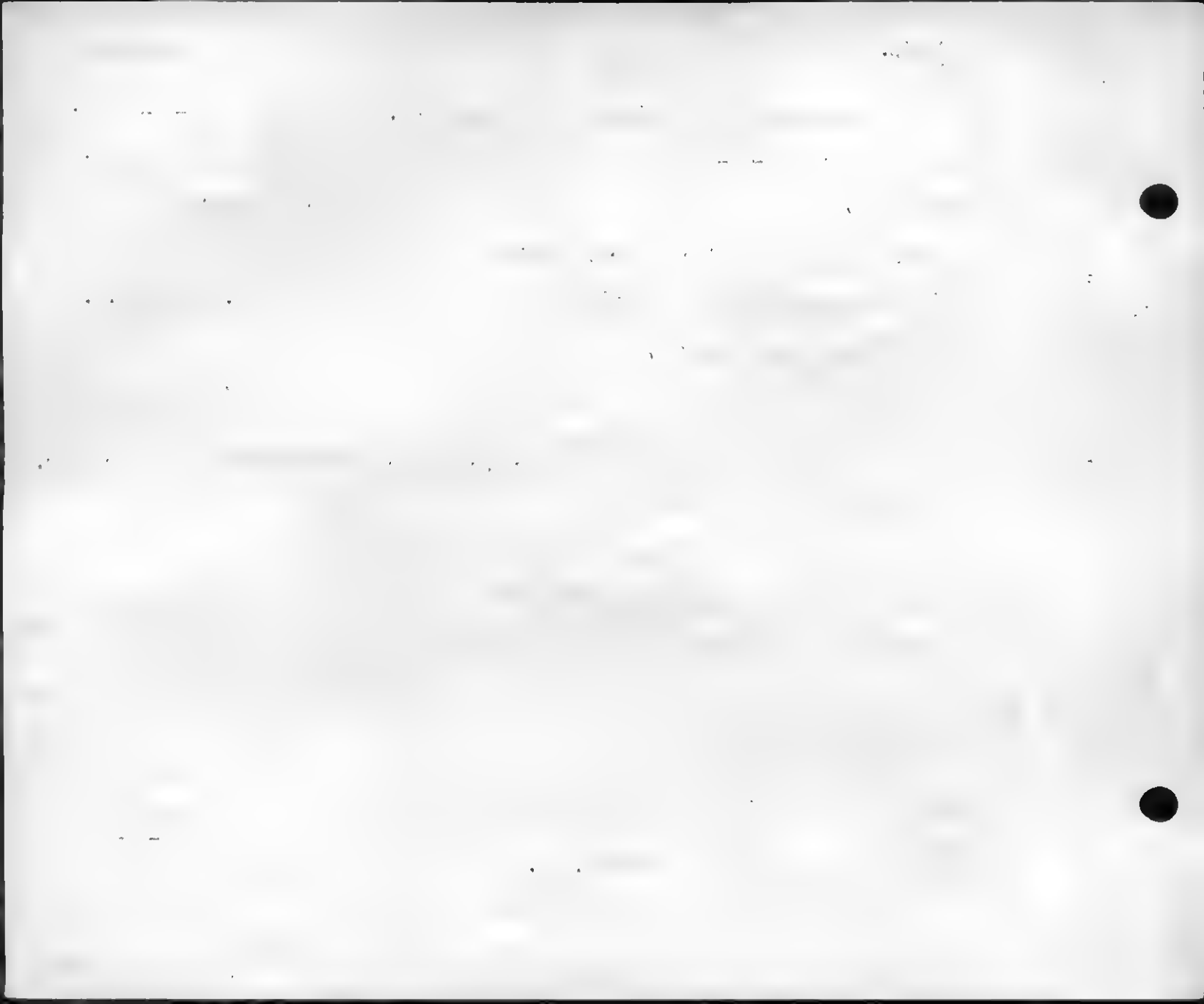
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14880

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14889

1. DECEASED NAME (Type or Print) First Middle Last <b>George Washington Hazel Jr.</b>			2a. DATE KNOWN OF DEATH Month Day Year <b>10-14-68</b>		2b. HOUR Minute <b>4:45am</b>
3 SEX <b>Male</b>	4 RACE <b>Negro</b>	5 DATE OF BIRTH <b>7-10-1932</b>	6. AGE (In years last birthday) <b>36</b> YRS	2c. DATE PRONOUNCED DEAD Month Day Year <b>10 14 68</b>	
7a. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Prince George's</b> Md.	
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince George Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>12b. KIND OF BUSINESS OR INDUSTRY</b>	
13a. USUAL RESIDENCE (Where deceased lived, if not in residence before death) State <b>District of Columbia</b> County <b>Washington</b>		13c. CITY OR TOWN <b>Washington</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>725 12th. Street N.E.</b>	
14. FATHER'S NAME First Middle Last <b>George Washington Hazel, Sr.</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Wilhelmina Kinard</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT ADDRESS <b>George Washington Hazel, Sr. - father</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO, OR AS A CONSEQUENCE OF <b>Arteriosclerotic heart disease</b> (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes over 1 yr.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year Hour A.M. P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>John Kehoe</b>		M.D.		22b. DATE SIGNED <b>10-15-68</b>	
EXAMINER'S NAME (Type) <b>John Kehoe MD Riverdale, Md.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASS STANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>10/19/68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Memorial Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Maryland</b>		
24. FUNERAL DIRECTOR <b>Stewart</b>	25a. REC'D BY REGISTRAR <b>Stewart</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

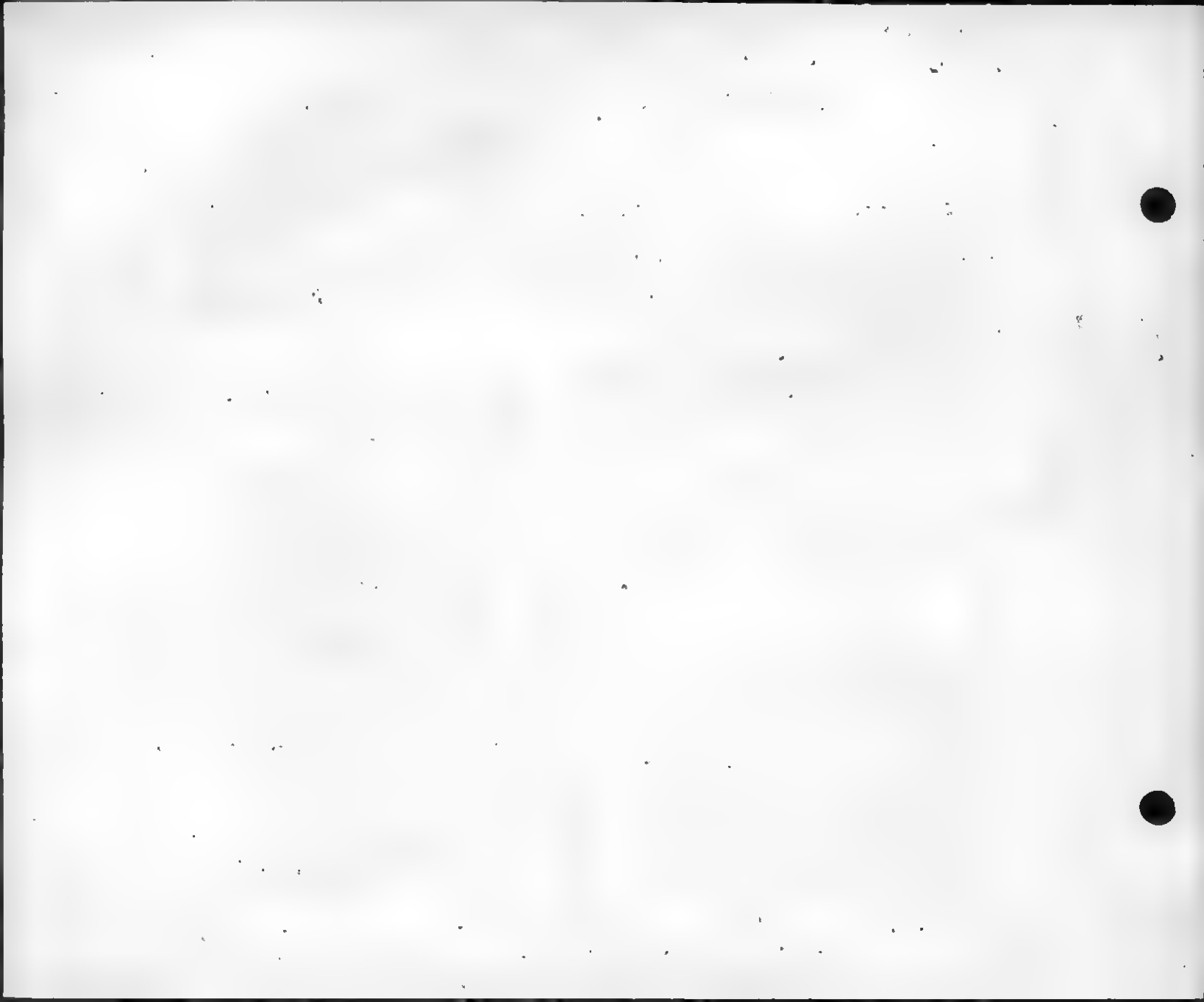
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14881

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

14890

1. DECEASED-NAME (Type or print) <b>Herman Middle Last</b> <b>HEBRON HEYERHANN N. Hebron</b>		2a. DATE OF DEATH Month <b>10</b> Day <b>15</b> Year <b>68</b> <b>5:30</b> HOUR	
3. SEX <b>Male</b>	4. RACE <b>Negro</b>	5. DATE OF BIRTH <b>9-4-24</b>	6. AGE (In years last birthday) <b>44</b> YRS.
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Prince Georges</b> Md
10. CITY OR TOWN OF DEATH <b>Riverdale, Maryland</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Leitch Memorial</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>MD.</b>	13b. COUNTY <b>Prince Georges</b>	13c. CITY OR TOWN <b>Lrentwood</b>	13e. STREET AND NUMBER <b>4507 Rhode Island Ave.</b>
14. FATHER'S NAME First <b>John</b> Middle <b>W.</b> Last <b>Hebron</b>	15. MOTHER'S MAIDEN NAME First <b>Florence</b> Middle <b>Hebron</b> Last <b>Hebron</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or dates of service)	16b. SOCIAL SECURITY NO. <b>Unk.</b>	17. INFORMANT <b>Florence Hebron-4507 Rhode Island Ave.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> <b>4107</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>MYOCARDIAL INFARCTION</b> (b) <b>3 WKS</b> DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 WK</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>PULMONARY EMBOLISM</b>			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>25 SEP. 1968</b> , to <b>15 OCT. 1968</b> , that (I) (we) last saw the deceased alive on <b>15 OCT. 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>C.J. HOUmann</b>	DEGREE <b>M.D.</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <b>16 OCT 1968</b>	
22d. PHYSICIAN'S NAME (Type) <b>C.J. HOUmann M.D.</b>	22e. ADDRESS <b>RIVERDALE</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>10-19-68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Church Cemetery</b>	23d. LOCATION (City or town) (County) (State) <b>Royds, Maryland</b>
24. FUNERAL DIRECTOR <b>John T. Rhines Company Funeral Home</b>	25a. REC'D BY REGISTRAR <b>DATE OCT 21 1968</b>		
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



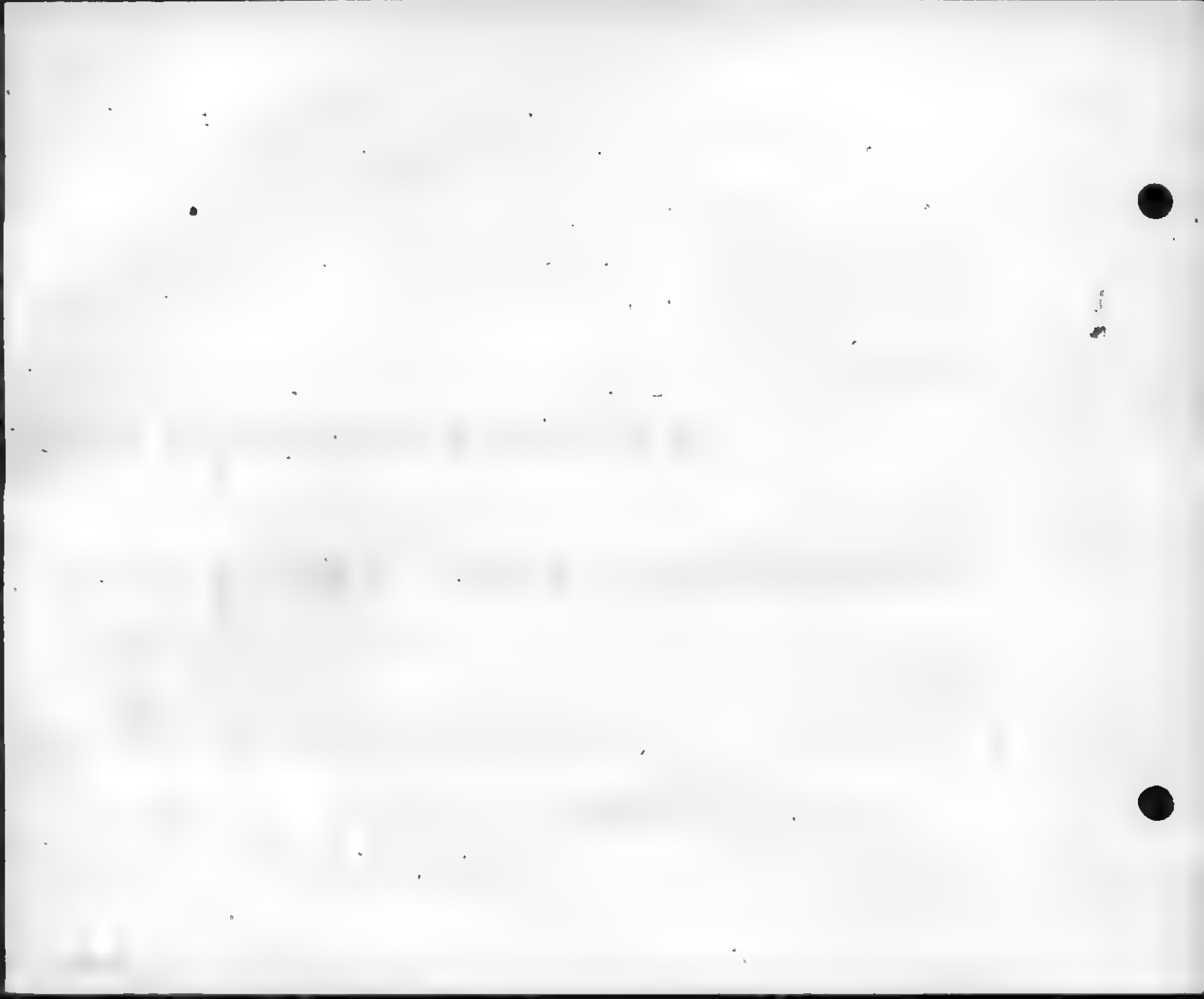


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

14882										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										14891																																							
1 DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR a.																																							
First Middle Last										Month Day Year										HOURS MIN																																							
Jennie F. Hipple										October 5 1968										7:30 AM																																							
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years last birthday)										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS HOURS MIN									
Female										White										July 20, 1897										71 YRS																													
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH																													
New York										United States																				Prince George										Md.																			
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																													
Hyattsville										Sacred Heart Home										Clerical																																							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET AND NUMBER																			
Maryland										Prince George										Landover										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										3318 Dodge Park Road																			
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME																																																	
First Middle Last										First Middle Last																																																	
Joseph Hipple										Jane McKeon																																																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) (If yes give war or dates of service)										16b. SOCIAL SECURITY NO.										17. INFORMANT										Address																													
no										068-09-3507										Sacred Heart Home										Hyattsville, Maryland																													
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Sustained Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Cardiac - Coronary Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Cardiac - Coronary Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF																														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hours																													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 68 2-13 68 10-3 68										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)																																							
21d. INJURY OCCURRED <input type="checkbox"/> White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from 10-3-68 to 10-3-68, that (I) (we) last saw the deceased alive on 10-3-68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE <u>Robert C. Hane</u>										22c. DATE SIGNED <u>10-5-68</u>																																																	
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS <u>35 NY Ave NW Wash DC</u>																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE <u>10/7/68</u>										23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cem.</u>										23d. LOCATION (City or Town) (County) (State) <u>Wash., D.C.</u>																													
24. FUNERAL DIRECTOR <u>Nalley's Funeral Home Inc.</u>										ADDRESS <u>Mt. Rainier, Maryland</u>										25a. REC'D BY REGISTRAR <u>DATE OCT 11 1968</u>										25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>																													



14883

## CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH			2b HOUR		
VIRGINIA		B		HITNER	Month	Day	Year	A M		
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		
Female		Cauc		11-5-1880		87 YRS.		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Pa.		U.S.				Prince George Md.				
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Forestville			Regent Nursing Home			HOMELIFE			HOME	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER	
MD.			A.A.		SHADYSIDE					
14 FATHER'S NAME			15 MOTHER'S M.A.D.E.N NAME							
First Middle Last			First Middle Last							
JOHN E DORAN			IDA K. MURPHY							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO.		17 INFORMANT Address					
					FRANK M. HITNER #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction									Immediate	
4! DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) Anteroseptal Heart Disease									10 yrs	
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
Gout & Osteoarthritis & Gout's disease										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 9/5/68 to 10/4/68, that (I) (we) last saw the deceased alive on 10/4/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE										
KELVIN L. MINCIN DEGREE										
22c. DATE SIGNED 10/4/68										
22d. PHYSICIAN'S NAME (Type) KELVIN L. MINCIN 6400 MERLBORO PINES										
22e. ADDRESS										
23a. BURIAL, CREMATION, REMOVAL (Specify)										
BURIAL										
23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
10-8-68		Arlington Nat'l.			Arlington Va.					
24. FUNERAL DIRECTOR										
John M. Taylor & Sons Company, Inc.										
25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE					
DATE OCT 7 1968					Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



4  
2  
5  
1  
3



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
<div>Item 6 F41mG406 11/8/68</div> <div>14888</div> <div>CERTIFICATE OF DEATH</div> <div>14893</div>											
1. DECEASED-NAME (Type or print) <b>SARAH D HOAN</b>						2a. DATE OF DEATH Month <b>10</b> Day <b>25</b> Year <b>1968</b>			2b. HOUR <b>8:24</b> M		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>7-7-88</b>			6. AGE (In years last birthday) <b>80</b> YRS		IF UNDER 1 YEAR MONTHS <b>11</b> DAYS <b>17</b>		IF UNDER 24 HRS. HOURS <b>11</b> MIN <b>24</b>
7a. BIRTHPLACE (State or foreign country) <b>U.S.A</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George Md.</b>					
10. CITY OR TOWN OF DEATH <b>Clinton</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Pine View Garden</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>MD</b>			13b. COUNTY <b>Mont.</b>		13c. CITY OR TOWN <b>Beth.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>9807 River Rd.</b>		
14. FATHER'S NAME First <b>ISAAC</b> Middle <b>JOHNSON</b> Last <b>JOHNSON</b>				15. MOTHER'S MAIDEN NAME First <b>JOHNSON</b> Middle <b>JOHNSON</b> Last <b>JOHNSON</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO		17. INFORMANT Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) - PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Circulatory collapse</b> <b>426.0</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>C. V. A., Cerebrovascular Accident</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>Arteriosclerotic hypertensive disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic hypertensive disease</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>201X</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>2-28-1967</b> , to <b>10-25-1968</b> , that (I) (we) last saw the deceased alive on <b>10-24-1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Alfred R. Lapina</b> DEGREE <b>MD</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>								22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) <b>ALFRED R. LAPINA</b>								22e. ADDRESS <b>CLINTON, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10-28-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wyoming Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Grandville, Michigan</b>				
24. FUNERAL DIRECTOR <b>Wilhelm Funeral Home 4308 Suitland Rd. S. E.</b>				ADDRESS		25a. REC'D BY REGISTRAR <b>NOV 1 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

116

14885

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14894

1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH			2b. HOUR		
William H. Hooker						Oct. 13, 1968			10:30 AM		
3 SEX			4. RACE			5 DATE OF BIRTH			6. AGE (In years lost birthday)		
Male			Caucasian			Jan. 25, 1892			76 YRS		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9 COUNTY OF DEATH		
Washington D C			U S A						Prince George's Md		
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince Geo.Gen'l Hospital			Retired clerk			Iron Works		
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Maryland			Prince George's			Hyattsville			7416 Allison Street		
14. FATHER'S NAME			15 MOTHER'S MAIDEN NAME								
Charles Hooker			Minnie Dreschler								
16a. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO			17 INFORMANT			Address		
no			578 17 3789A			Minnie O' Connor			Hyattsville, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of prostate</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>2 yrs.</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 3/9/1964 to 10/13/1968, that (I) (we) last saw the deceased alive on 10/13/1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (didn't) view the body after death.											
22b SIGNATURE						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
Frederick E. Musser, M. D.						4410 74th Ave. Bellmead, Md. 20784					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			Oct 16, 1968			Cedar Hill Cemetery			Suitland Pro Geo Md.		
24 FUNERAL DIRECTOR						25a REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
F. Gasch's Sons Hyattsville, Md						DATE OCT 16 1968			Charles Judge		





## CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH			2b. HOUR	
LOTTIE				HUTCHINGS	Month	Day	Year	2:06 PM	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	White		Feb. 7. 1877		91 YRS.		MONTHS	DAYS	HOURS
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
N. Carolina	U. S. A.				Prince Georges Md				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Adephi		2717 Hughes Road		at Home		Same			
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md		Or Geo		Adephi				2717 Hughes Road	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S M.A.DEN NAME		First	Middle	Last
Theodor				White	Marion				Hare
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
				Mr. Juanitor M. Guild		(same as #2)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Anteriosclerotic heart disease								10 yrs.	
4129 DUE TO, OR AS A CONSEQUENCE OF (b) Senility									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
DUE TO, OR AS A CONSEQUENCE OF (c) Anteriosclerosis								12 yrs.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
7									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 1957, 19, to Oct. 26, 1968, that (I) (we) last saw the deceased alive on 10/24/68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED							
A.W. Smith M.A.		10/26/68							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
A.W. SMITH		13018 GEORGIA AVE WHEATON, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Oct. 29. 1968		Ford Lincoln Cemetery		Colman Manor Md			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
J. Charles Wallers		254 Canal Blvd LA		OCT 29 1968		J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14887		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		14896	
Item 3 Film G405 10-1-68		CERTIFICATE OF DEATH			
1. DECEASED NAME (Type or print) First Middle Last NORA A HUTTEL		2a. DATE OF DEATH 16 Month Oct Day 16 Year 68		2b. HOUR 11:50 A.M.	
3 SEX Female MALE	4 RACE WHITE	5. DATE OF BIRTH 25 Jan. 1888		6. AGE (In years last birthday) 80 YRS.	7. UNDER 1 YEAR MONTHS 8 DAYS 21
7a. BIRTHPLACE (State or foreign country) BUFFALO, NEW YORK U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH PRINCE GEORGES COUNTY Md.	
10 CITY OR TOWN OF DEATH FORESTVILLE, MD.		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 4101-SUIT ROAD		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if ret. red.) HOUSEWIFE	
12b. KIND OF BUSINESS OR INDUSTRY HOME MAKER		13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE D.C.		13b. CITY OR TOWN WASH. D.C.	
13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER 2600-QUEENS CHAPEL ROAD		13e. D.N.E.	
14 FATHER'S NAME First Middle Last WILLIAM KURTZ		15. MOTHER'S MAIDEN NAME First Middle Last AMELIA KURTZ			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17 INFORMANT FORESTVILLE, MARYLAND JOHN W. HUTTEL (SON) 4101 SUIT ROAD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cardiac arrest 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) Failure of pacemaker					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from Sept. 1, 1966, to 16 Oct., 1968, that (I) (we) last saw the deceased alive on 11 Oct., 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Thomas B. Mattingly, M.D.		22c. DATE SIGNED 16 Oct 1968		22d. ADDRESS 2200 Rhode Is. Ave. N.E. D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 10/18/1968		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY	
23d. LOCATION (City or Town) (County) (State) SUITLAND, MARYLAND					
24. FUNERAL DIRECTOR MARTIN W. HYSONG COMPANY		25a. REC'D BY REGISTRAR OCT 18 1968		25b. REGISTRAR'S SIGNATURE Charles J. J...	

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

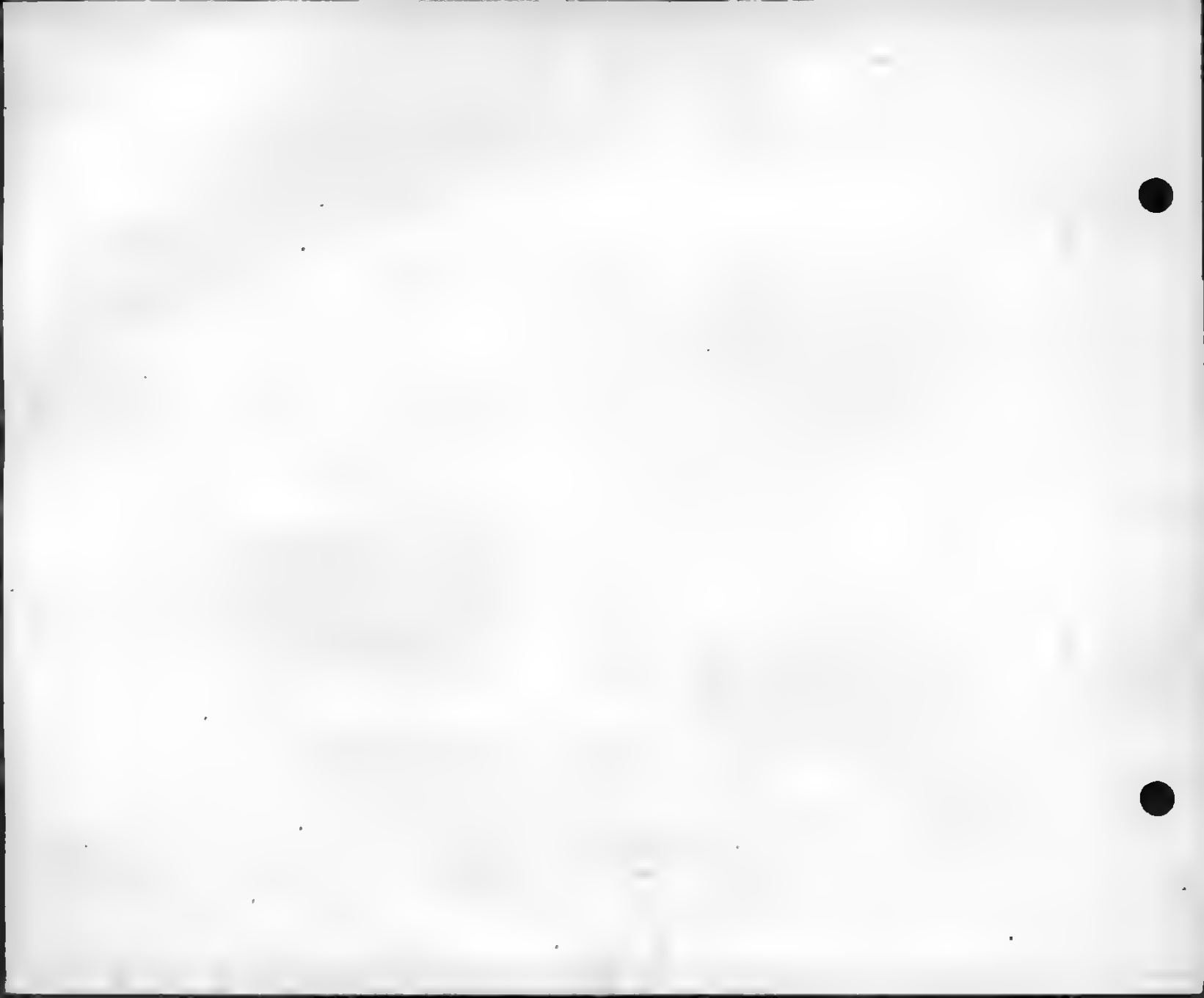
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14888

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14897

1. DECEASED NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> Month	<input type="checkbox"/> Day	<input type="checkbox"/> Year	2b. HOUR
Margaret		S	Jones		10/30/1968		10	30	1968	40
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	7. IF UNDER 1 YEAR MONTHS	8. IF UNDER 24 HRS HOURS	9. DATE PRONOUNCED DEAD	10. Month	11. Day	12. Year	13. HOUR
female	white	March 1, 1884	84 YRS			10/30/68	10	30	1968	M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Alabama		U S A				Prince George's		Md		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Lanham		Magnolia Nursing Home				housewife		home		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Md		Pro George's		Riverdale		YES <input type="checkbox"/> NO <input type="checkbox"/>		6321 Kenilworth avenue,.		
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME						
First Middle Last				First Middle Last						
Henry C Smilie				Ella Parker						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO		17. INFORMANT ADDRESS				
no						Ella Spicer Riverdale, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary embolus										minutes
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
Arteriosclerotic heart disease- yrs. Fracture rt femur 15 days										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
17 Oct				Fracture 6d left femur				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
CAUSE OF DEATH		6:30pm 10 15 19 68		Died at home						
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State						
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		home		6321 Kenilworth Ave., Hyattsville P.G. Md.						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b. DATE SIGNED		
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER				10-30-68		
John Kehoe, M.D., Riverdale				DEPUTY MEDICAL EXAMINER				ADDRESS (Street, city, town, or county)		
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
burial				Nov 2, 1968		Ft Lincoln Cemetery		Colmar Manor Pro Geo Md.		
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR		
F. Gasch's Sons Hyattsville, Md.								25b. REGISTRAR'S SIGNATURE		
				DATE NOV 4 1968				Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
148898												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) <b>THETUS A. JORDAN</b>						2a. DATE OF DEATH Month <b>Oct</b> Day <b>25</b> Year <b>1968</b>			2b. HOUR <b>4A.M.</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH <b>OCT 14, 1912</b>			6. AGE (In years last birthday) <b>56</b> YRS.		7. IF UNDER 1 YEAR MONTHS <b>56</b> DAYS <b>00</b> HOURS <b>00</b> MIN <b>00</b>		8. IF UNDER 24 HRS. HOURS <b>00</b> MIN <b>00</b>	
7a. BIRTHPLACE (State or foreign country) <b>NORTH CAROLINA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <b>PRINCE GEORGES</b> Md.						
10. CITY OR TOWN OF DEATH <b>CHEVERLY</b>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>PRINCE GEORGES GEN HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>R.R. CAR CLEANER</b>				12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>D.C.</b> COUNTY <b>D.C.</b>				13c. CITY OR TOWN <b>WASHINGTON</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>724 HAMLIN ST. N.E.</b>				
14. FATHER'S NAME First <b>JAMES</b> Middle <b>ALLEN</b> Last <b>MAUDE</b>				15. MOTHER'S MAIDEN NAME First <b>MAUDE</b> Middle <b>UNDERWOOD</b> Last <b>UNDERWOOD</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. <b>R.R. RETIREMENT</b>		17. INFORMANT <b>CHARLOTTE SHERRY</b> Address <b>5620 WHITEFIELD CHAPEL RD LANHAM MD.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <b>Arteriosclerotic vascular disease</b> (b) <b>Diabetes mellitus</b> (c) <b>Hypertension for at least 20 years</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <b>19</b> Month <b>10</b> Day <b>26</b> Year <b>1968</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. <b>403 E CAPITOL ST</b> City or Town <b>WASHINGTON</b> County <b>D.C.</b> State <b>D.C.</b>								
22a. I certify that (I) (this hospital) attended the deceased from <b>7-6</b> , 19 <b>44</b> , to <b>10-26</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>10-21</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>Claudine M. Gay MD</b>						22c. DATE SIGNED <b>10-26-68</b>						
22d. PHYSICIAN'S NAME (Type) <b>CLAUDINE M. GAY, MD</b>						22e. ADDRESS <b>403 E CAPITOL ST WASH. DC</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>OCT 28, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FORT LINCOLN CEM</b>		23d. LOCATION (City or Town) <b>CLMAR MANOR</b> (County) <b>MARYLAND</b> (State)						
24. FUNERAL DIRECTOR <b>W. W. CHAMBERS CO. RIVERDALE, MD.</b>				25a. REC'D BY REGISTRAR <b>NOV 6 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>						





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First <del>ANNA</del> MIDDLE <del>ANNA</del> LAST <del>ANNA</del> <b>KASH</b>			2a. DATE OF DEATH Month <b>OCT</b> Day <b>13</b> Year <b>1968</b>			2b. HOUR <b>4:30 PM</b>		
3. SEX <b>FEMALE</b>			4. RACE <b>CAU.</b>			5. DATE OF BIRTH <b>15 JAN. 1887</b>			6. AGE (In years last birthday) <b>81</b> YRS.		
7a. BIRTHPLACE (State or foreign country) <b>KENTUCKY</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Princ George</b> Md.		
10. CITY OR TOWN OF DEATH <b>GREENBELT</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>GREENBELT NURSING HOME</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>RET. TEACHER</b>			12b. KIND OF BUSINESS OR IND. STRY <b>PUBLIC SCHOOL</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE <b>MARYLAND</b>			13b. CITY OR TOWN <b>PRINCE GEORGE</b>			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>26 WOODLAND WAY</b>		
14. FATHER'S NAME First Middle Last <b>PLEASANT B. BROADDUS</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>MARY C. COCKRELL</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, <b>NO</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO <b>405-28-6609</b>		
17. INFORMANT <b>HOWARD B. KASH SON SAME AS ABOVE</b>			Address <b>SON SAME AS ABOVE</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. <b>Pneumonia</b> (b) <b>24 hours</b> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Secret</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>① Cerebral Arteriosclerosis ② Substernal Thyroid compressing trachea</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>July 1968</b> to <b>OCT 13 1968</b> , that (I) (we) last saw the deceased alive on <b>10-13</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>William C. Wentz MD</b>						DEGREE <input checked="" type="checkbox"/> MED <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>10/16/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>HILLCREST MEMORIAL PARK</b>			23d. LOCATION (City or Town) (County) (State) <b>LEXINGTON KENTUCKY</b>		
24. FUNERAL DIRECTOR <b>F. GASCH'S SONS</b>						ADDRESS <b>HYATTSVILLE, MARYLAND</b>			25a. REC'D BY REGISTRAR <b>OCT 16 1968</b>		
						25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

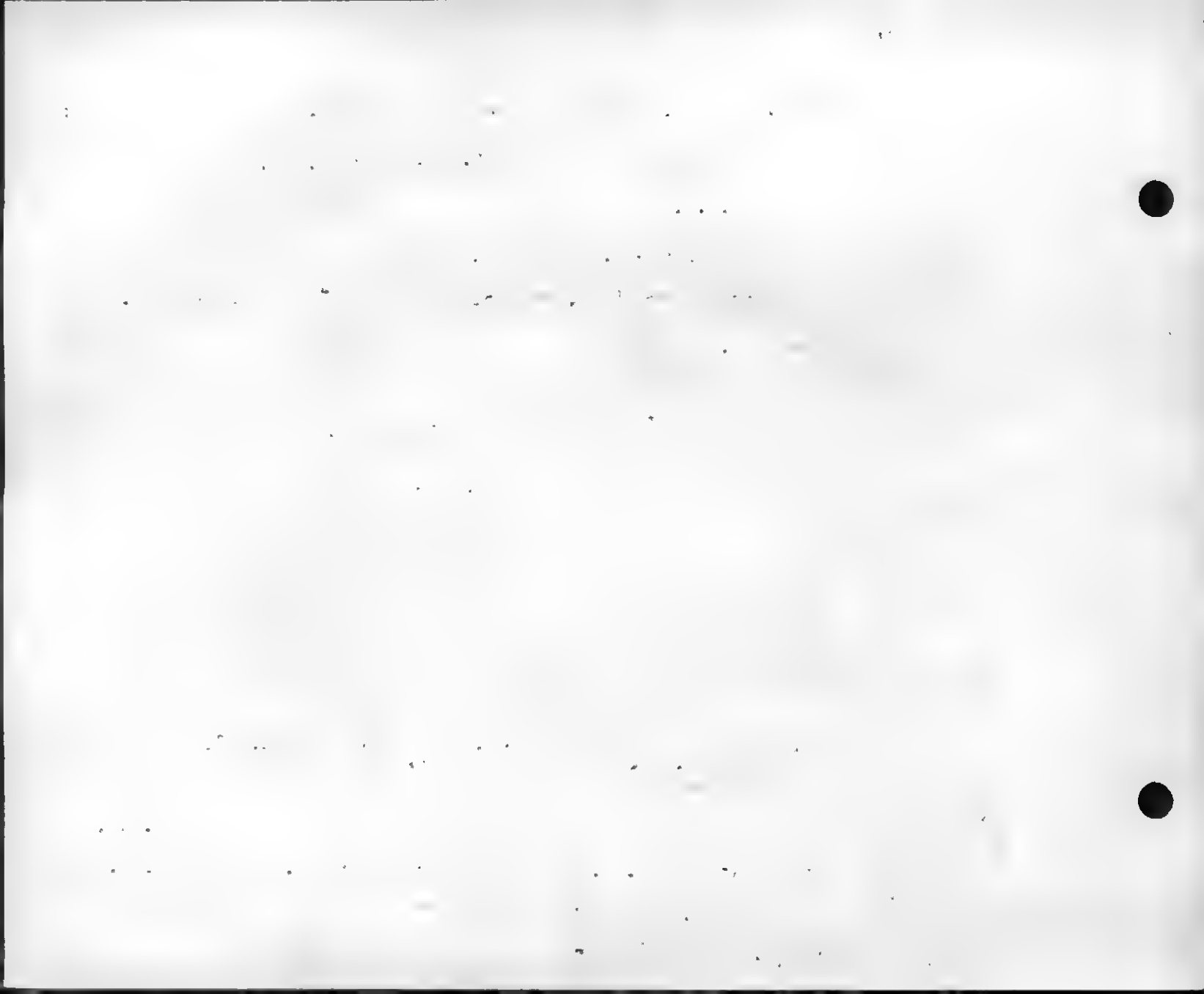


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VR A15 (4)  
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR			
Baby Girl Keenan						Oct. Month 22, Day 1968 Year			9:10PM			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		7. UNDER YEAR		7. UNDER 24 HRS	
Female		Caucasian		Oct. 22, 1968			YRS.		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
Maryland		U.S.A.				Prince George's Md						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
Cheverly			Prince Geo. Gen'l Hospital									
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Prince George's			E. Riverdale		YES <input type="checkbox"/> NO <input type="checkbox"/>		5519 Nicholson St.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME									
First Middle Last			First Middle Last									
Charles E. Keenan			Patricia Stockstill									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO			17. INFORMANT			Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Anomalous placental previa</u>												
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												
DUE TO, OR AS A CONSEQUENCE OF												
(b) _____												
(c) _____												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
21a. DATE OF OPERATION												
21b. CONDITION FOR WHICH OPERATION WAS PERFORMED												
21c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>												
21d. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?												
21e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)												
21f. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M.												
21g. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)												
21h. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>												
21i. PLACE OF INJURY (AT HOME FARM STREET FACTORY) OFFICE BUILDING, ETC.												
21j. LOCATION Street or R.F.D. No City or Town County State												
22a. I certify that (I) <u>(the hospital)</u> attended the deceased from <u>Oct. 22, 1968</u> , to <u>Oct. 22, 1968</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>Oct. 22, 1968</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> (did) <u>(did not)</u> view the body after death.												
22b. SIGNATURE <u>[Signature]</u>												
22c. DATE SIGNED <u>Oct. 24, 1968</u>												
22d. PHYSICIAN'S NAME (Type) <u>Iradj Mahadavi, M. D.</u>												
22e. ADDRESS <u>6821 Riverdale Rd., Riverdale, Md. 20840</u>												
23a. BURIAL, CREMATION, REMOVAL (Specify)												
23b. DATE <u>11-2-68</u>												
23c. NAME OF CEMETERY OR CREMATORY <u>Prince George's General Hospital</u>												
23d. LOCATION (City or Town) (County) (State) <u>Cheverly, Maryland</u>												
24. FUNERAL DIRECTOR <u>[Signature]</u> ADDRESS <u>1100 W. Penn, Jr., Administrator</u>												
25a. REC'D BY REGISTRAR <u>NOV 6 1968</u>												
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>												



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14892

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14901

1. DECEASED NAME (Type or Print) Theodore Lewis Keys			2a. DATE KNOWN OF DEATH Month Day Year 10-21-68 19:11:45pm		2b. HOUR
3. SEX Male	4. RACE Negro	5. DATE OF BIRTH 5-8-1937	6. AGE (in years last birthday) 31 YRS	7c. DATE PRONOUNCED DEAD Month Day Year 10-22-68 1:40am	2d. HOUR
7a. BIRTHPLACE (State or foreign country) D.C.		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince George's Md.	
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital		12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired)	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE District of Columbia		13b. COUNTY Washington	13c. CITY OR TOWN Washington	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 1409 15th. Street N.W.
14. FATHER'S NAME First Middle Last Nathan Keys		15. MOTHER'S MAIDEN NAME First Middle Last Juanita Bates			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO (If yes, give number and dates of service) WII 577-50-2552		17. INFORMANT ADDRESS Donna Keys 4545 Wheeler Rd SE, D.C.	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Bilateral hemothorax</u> DUE TO, OR AS A CONSEQUENCE OF <u>Gun shot wounds of chest</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year 11:44am 10-21-19 68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Shot by assailant.	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Parking lot of 1500 Southern Ave., Prince George's County, Maryland			
21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspect an <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)		22b. DATE SIGNED 10-22-68	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Oct 26, 1968		23c. NAME OF CEMETERY OR CREMATORY HARMONY MEM. Park	
23d. LOCATION (City or Town) Landover		(County) Md		(State)	
24. FUNERAL DIRECTOR JOHNSON & JENKINS FUN. HOME INC. 4804 GA. AVE NW WASH. D.C.		25a. REC'D BY REGISTRAR OCT 28 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (S)  
10M REV 1/68

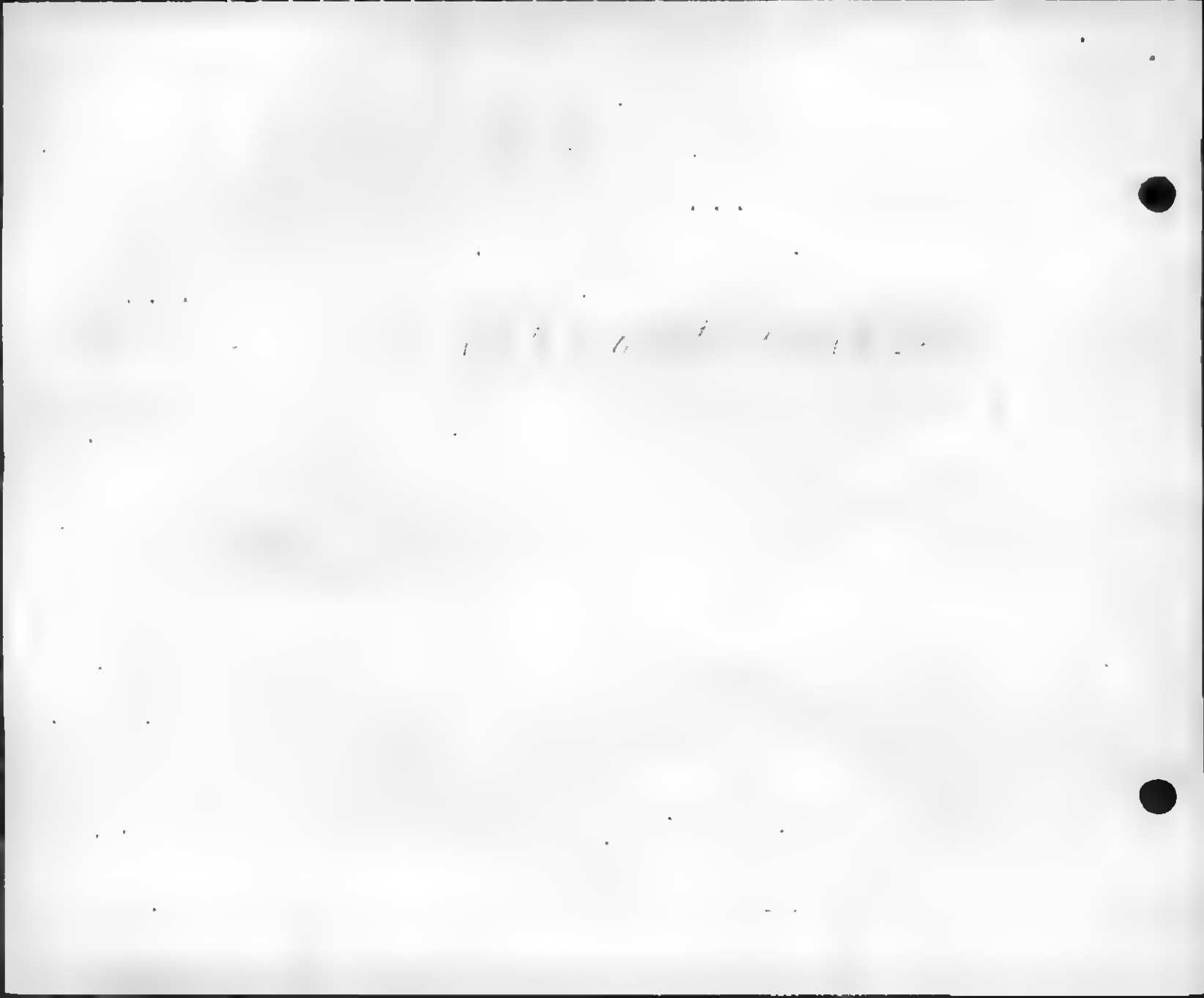
14893

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14902

1 DECEASED NAME (Type or Print)		First Elijah		Middle M.		Last Kinney		2a DATE KNOWN OF DEATH		Month 10-8	Year 1968	2b HOUR 3:40 pm					
3 SEX M	4 RACE Negro	5 DATE OF BIRTH 2-8-1912	6 AGE (In years last birthday) 56 YRS	7 UNDER 1 YEAR MONTHS DAYS		8 UNDER 24 HRS HOURS MIN.		2c DATE PRONOUNCED DEAD Month 10		Day 8	Year 1968	2d HOUR 3:40 pm					
7a BIRTHPLACE (State or foreign country) Virginia		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince George											
10 CITY OR TOWN OF DEATH Glendale, Md.		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Glendale Hosp.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Street Cleaner		12b KIND OF BUSINESS OR INDUSTRY ---											
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE DC		13b COUNTY Washington		13c CITY OR TOWN YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER 24 Bryant St., N.E.									
14 FATHER'S NAME First Thomas				Middle F.				Last Kinney				15 MOTHER'S MAIDEN NAME First Mary		Middle --		Last Miner	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO (If yes give war or dates of service) 577-50-9399		17 INFORMANT Decedent		ADDRESS											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Barbiturate intoxication</u> 7800 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hrs.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)																	
19a DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year HOUR A.M. PM P.M. 10-8 19 68				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Unknown - Took overdose of barbiturate									
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Hospital				21f LOCATION Street or R.F.D. No. City or Town County State Glendale P.G. Md.									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/>																	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)				22b DATE SIGNED 22- 2-14-68									
23a BURIAL, CREMATION, REMOVAL (Specify) Burial				23b DATE 10-9-68				23c NAME OF CEMETERY OR CREMATORY Lincoln Memorial				23d LOCATION (City or Town) (County) (State) Suitland, Maryland					
24 FUNERAL DIRECTOR Peyton Funeral Home, 2205 Shirlington, Virginia				ADDRESS Arlington				25a REC'D BY REGISTRAR DATE FEB 19 1969				25b REGISTRAR'S SIGNATURE Charles Judge					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

14896

14903

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)		First Anna	Middle E.	Last Kirby	2a. DATE OF DEATH Month Day Year October 12 1968			2b. HOUR 4:45 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH December 16, 1877		6. AGE (In years last birthday) 90 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George Md			
10. CITY OR TOWN OF DEATH Hyattsville		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Sacred Heart Home		12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired) Housework		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE District		13b. COUNTY of Columbia		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1046 Wisconsin Avenue, N.W.	
14. FATHER'S NAME First Middle Last Kearns Andrew Kirby		15. MOTHER'S MAIDEN NAME First Middle Last Mary E. McCormick							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		16b. SOCIAL SECURITY NO (If yes give war or dates of service) 216-46-7225		17. INFORMANT Address Sacred Heart Home Hyattsville, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis &amp; myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF <u>arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>4-28</u> , 19 <u>59</u> , to <u>10-12</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>10-12</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.									
22b. SIGNATURE <u>Thomas F Collins</u>		DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>10-12-68</u>			
22d. PHYSICIAN'S NAME (Type) THOMAS F COLLINS		22e. ADDRESS <u>322-H 01 NE</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Oct. 15, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>			
24. FUNERAL DIRECTOR <u>W. J. McDonough - Murphy &amp; A. R. V.</u>		ADDRESS		25a. REC'D BY REGISTRAR DATE <u>OCT 15 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATION

lain

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 15  
30M REV 1-68

14895				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				14904																			
1. DECEASED NAME (Type or print)				First Middle Last				2a. DATE OF DEATH				2b. HOUR															
MARY				PAGE KNAPP				October 10 1968				3A.M															
3. SEX				4. RACE				5. DATE OF BIRTH				6. AGE (In years last birthday)				IF UNDER 1 YEAR MONTHS DAYS				IF UNDER 24 HRS HOURS MIN							
Female				White				November 28, 1884				83 YRS.															
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH															
Virginia				U.S.A.								Prince Georges								Md							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY															
Upper Marlboro				XXXXX Church Road				Housewife				XXXXX				Own Home											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				13b. CITY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET AND NUMBER				13f. CHURCH							
Maryland				Prince Georges				Upper Marlboro								XXXXX Church Road											
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME																							
First Middle Last				First Middle Last																							
Henry Deane Page				XXXXXXX Sarah Gregg																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO.				17. INFORMANT																			
NO								Mr. John Page - "Bowieville", Church Rd.																			
								Upper Marlboro, Md.																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))																											
PART I. DEATH WAS CAUSED BY:																											
IMMEDIATE CAUSE (a)				DUE TO, OR AS A CONSEQUENCE OF:																							
4177				Myocardial insufficiency																years							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost				(b)				arteriosclerotic heart disease												years							
				(c)				generalized arteriosclerosis												years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)																											
71111																											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?															
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)																			
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (the hospital) attended the deceased from 1973, to 10/10/68, 1973, that (I) (we) last saw the deceased alive on 10/10/68, 1973, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death.																											
22b. SIGNATURE				22c. DATE SIGNED																							
Emily H. Wilson M.D.				10/11/68																							
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS																							
Emily H. Wilson, M.D.				Lothian, Maryland 20820																							
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)															
Burial				Oct. 12, 1968				St. Barnabas Episc. Leland Pr. Geor Md.																			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE																			
Ritchie Bros. Funeral Home Md.				Upper Marlboro				DATE OCT 16 1968				J. Charles Judge															

XXXXXX

XXXXXX

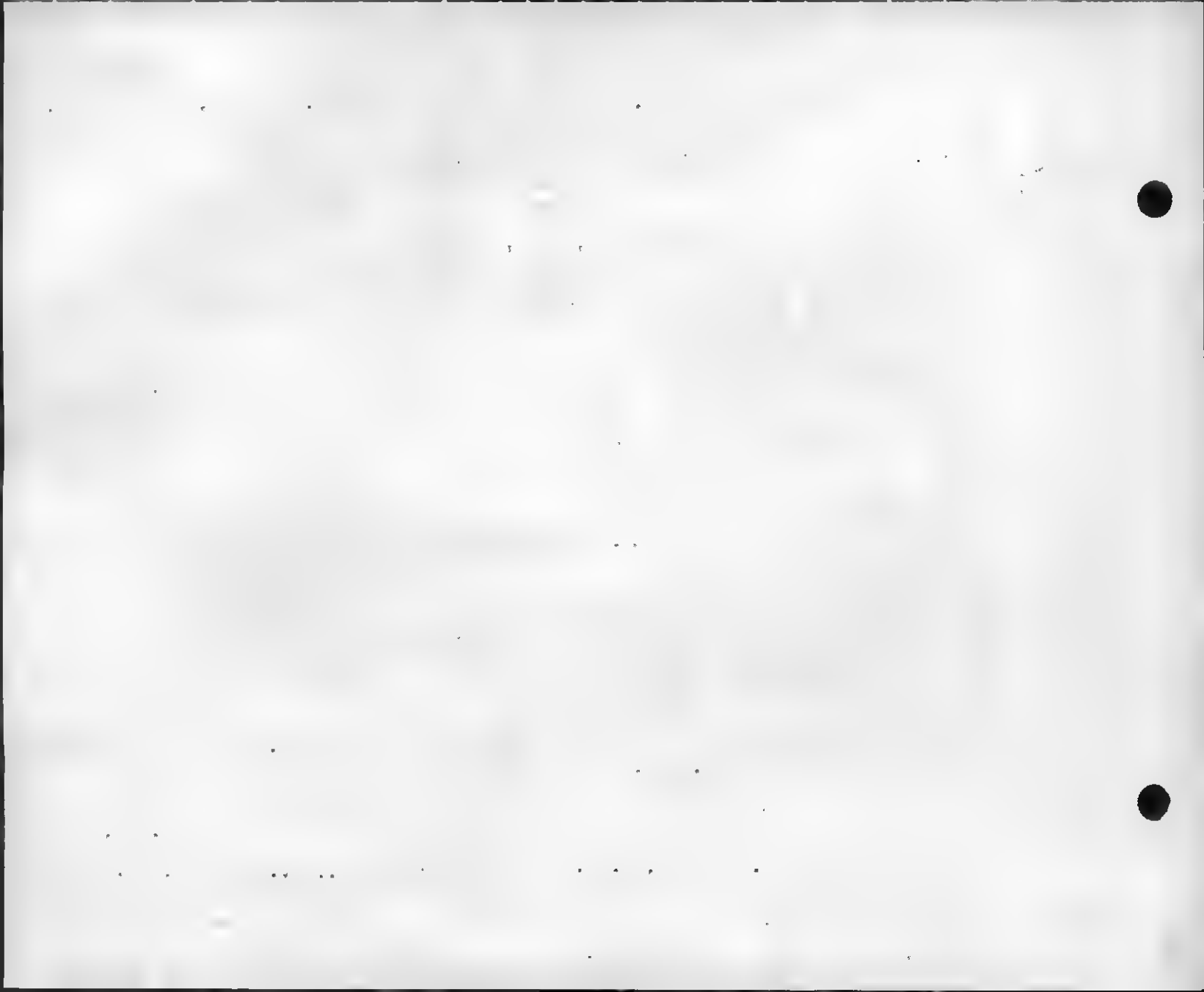
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I.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>14896</div> <div> <div>1</div> <div>2</div> </div> <div> <div>14905</div> <div>1</div> </div>													
1 DECEASED-NAME (Type or print)				First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
Lena				E.		KNOX		Oct.		Month 28, Day 1968		10:25 AM	
3 SEX		4 RACE		5. DATE OF BIRTH				6 AGE (n years last birthday)		7 UNDER 1 YEAR		IF UNDER 24 HRS	
Female		Caucasian		12-03-06				61 YRS		MONTHS		DAYS	
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH							
Va		U S A		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Prince George's						Md	
10. CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Cheverly				Prince George's Gen'l Hospital				Retired phone operator					
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)				13b. COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland				Anne Arundel		Annapolis		YES <input type="checkbox"/> NO <input type="checkbox"/>		Severn Grove Circle			
14 FATHER'S NAME				First		Middle		Last		15 MOTHER'S MAIDEN NAME		First Middle Last	
George Turner Hepner										Terzah Amelia Celler			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b SOCIAL SECURITY NO		17 INFORMANT		Address					
no				578 10 0702		Herman T Knox		Annapolis, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>carcinomatosis</u>													
174X DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													
(b) DUE TO, OR AS A CONSEQUENCE OF													
(c) <u>adenocarcinoma of the breast</u>												18-month	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
170X													
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)									
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) <del>the hospital</del> attended the deceased from <u>March</u> , 19 <u>67</u> , to <u>Oct. 28</u> , 19 <u>68</u> , that (I) <del>we</del> last saw the deceased alive on <u>Oct. 28</u> , 19 <u>68</u> , and that in (my) <del>last</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>we</del> (did) <del>not</del> view the body after death.													
22b SIGNATURE <u>Don B. Cameron</u>				DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED <u>Oct. 28, 1968</u>					
22d PHYSICIAN'S NAME (Type)				3503 Perry St., Mt. Rainier, Md. 20822									
23a BURIAL, CREMATION, REMOVA (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)							
Burial		Nov 1, 1968		Ft Lincoln Cemetery		Colmar Manor, Pro Geo Md.							
24 FUNERAL DIRECTOR				ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE					
F. Gasch's Sons				Hyattsville, Md.		DATE NOV 4 1968		<u>Charles Judge</u>					



FOR STATE  
HEALTH DEPT.

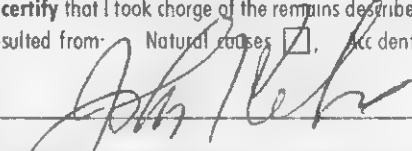

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute this certificate, writing the word "pending" in pencil in the space provided on Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

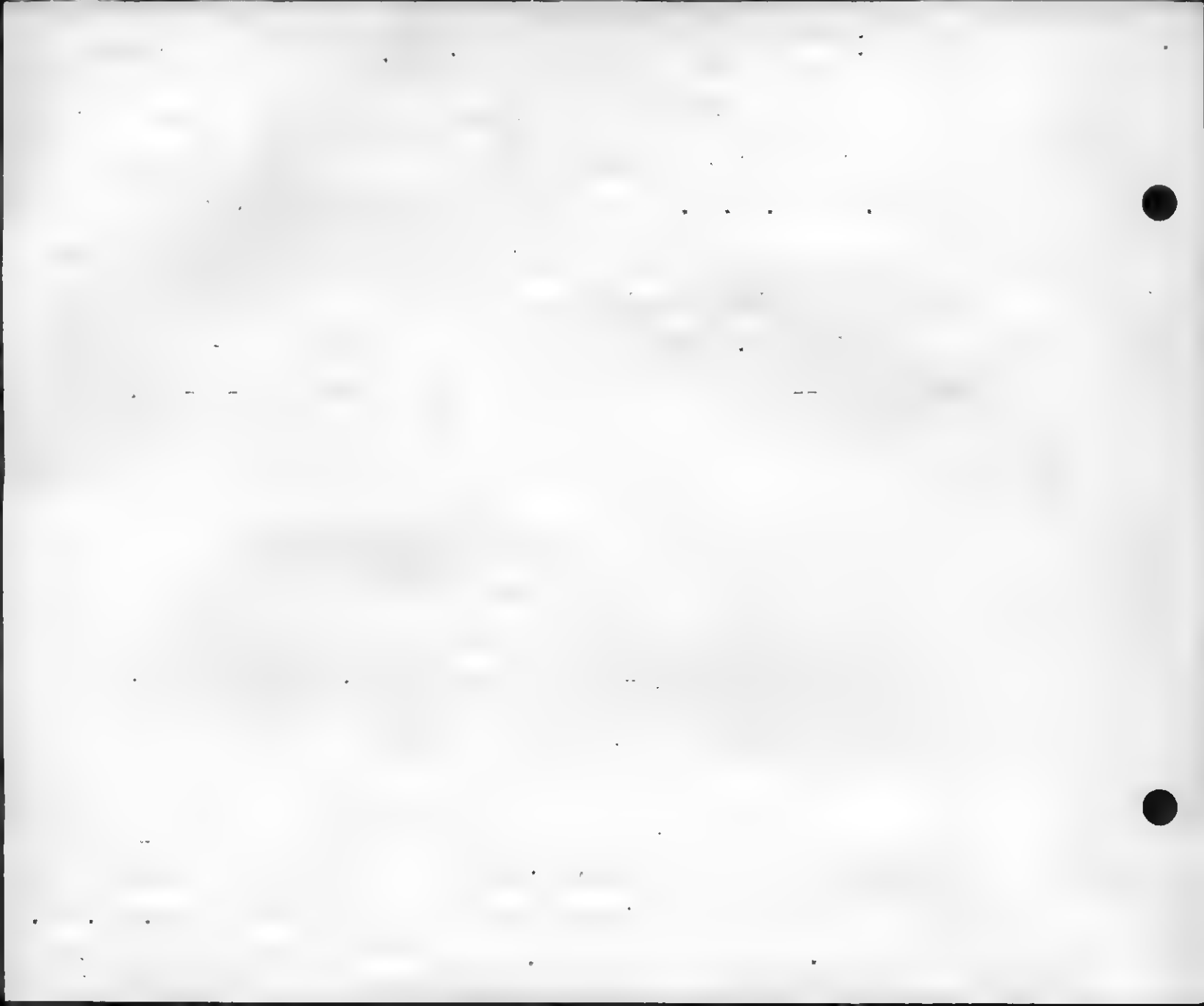
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14897

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14906

1 DECEASED NAME (Type or Print) First Middle Last <b>Francis Cleveland Kolbe</b>			2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 10-31-68 193:00pm			2b HOUR		
3 SEX <b>Male</b>	4 RACE <b>White</b>	5. DATE OF BIRTH <b>11-23-1893</b>	6 AGE (in years last birthday) <b>74</b> YRS.	7 UNDER 1 YEAR MONTHS DAYS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year <b>10 31 68 197:10pm</b>		2d HOUR
7a. BIRTHPLACE (State or foreign country) <b>Penna.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Prince George's</b> Md		
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince George Hospital</b>		12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) <b>Tobacco Farmer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Prince George's</b>		13c. CITY OR TOWN <b>Upper Marlboro</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>7000 Woodyard Road</b>
14 FATHER'S NAME First Middle Last <b>Philip Wm. Kolbe</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Clara -- Schaffer</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>Unknown</b>		
16b. SOCIAL SECURITY NO. <b>Unknown</b>			17 INFORMANT <b>Bertha Elizabeth Kolbe-13-e-c.</b>			ADDRESS Same as Items		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gun shot wound of head</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>976x</b>								
19a. DATE OF OPERATION <b>11-5-68</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day Year HOUR A.M. <b>3:00pm 10-31- 19 68</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Shot self with .12 gauge shot gun.</b>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Barn in rear of home</b>		21f. LOCATION Street or R.F.D. No. City or Town County State <b>same as #13</b>				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE 			M.D.			22b. DATE SIGNED <b>11-1-68</b>		
EXAMINER'S NAME (Type) <b>John Kehoe MD</b>			<b>Riverdale, Md.</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>11/5/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Epiphany Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Forestville Pr. Geo. Md.</b>		
24. FUNERAL DIRECTOR <b>Ritchie Bros. Upper Marlboro, Md.</b>				25a. REC'D BY REGISTRAR <b>NOV 12 1968</b>		25b. REGISTRAR'S SIGNATURE 		

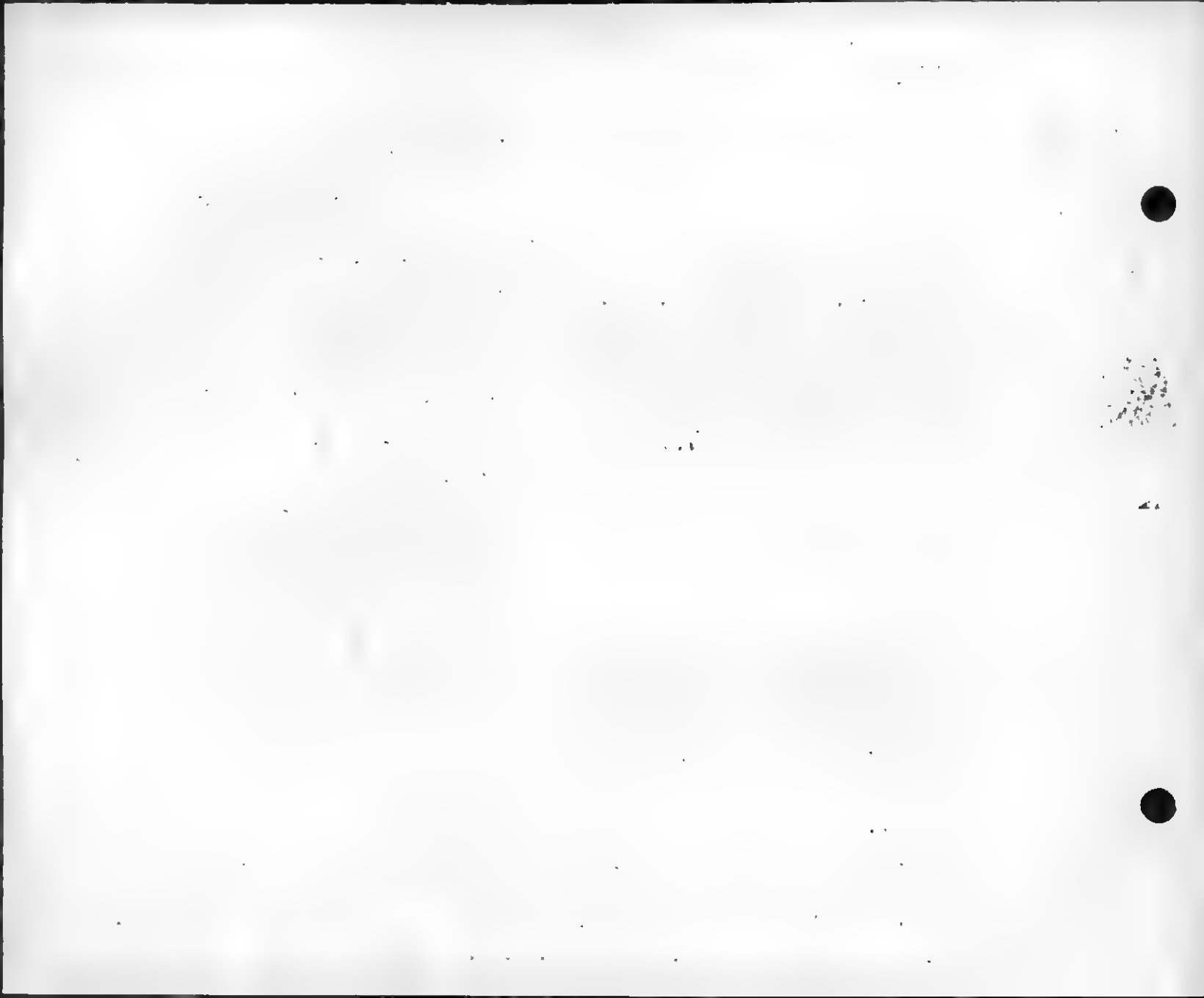




TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print) <b>PETER</b>			First <b>WALTER</b>			Middle <b>LARSON</b>			Last	
3 SEX <b>Male</b>			4 RACE <b>Caucasian</b>			5 DATE OF BIRTH <b>12-19-1894</b>			6a DATE OF DEATH Month <b>10</b> Day <b>13</b> Year <b>68</b>	
7a BIRTHPLACE (State or foreign country) <b>Michigan</b>			7b CITIZEN OF WHAT COUNTRY? <b>U S A</b>			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Prince George</b>	
10 CITY OR TOWN OF DEATH <b>Captain's Cove</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>9214 Reed Lane</b>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Auto. mechanic</b>			12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Md.</b>			13b COUNTY <b>Pr. Geo.</b>			13c CITY OR TOWN <b>Captain's Cove</b>			13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
14 FATHER'S NAME First <b>Peter</b>			Middle <b>Larson</b>			15. MOTHER'S MAIDEN NAME First <b>Victoria Carlson Larson</b>			Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>No</b>			16b. SOCIAL SECURITY NO. <b>370-05-5103</b>			17. INFORMANT <b>Lulu M. Larson</b>			Address <b>9214 Reed Lane</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cancer of Stomach</b>										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>metastases</b>										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION										
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										
20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>										
20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										
21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b>										
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)										
21d INJURY OCCURRED <input type="checkbox"/> While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work										
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										
21f. LOCATION Street or R.F.D. No. City or Town County State										
22a. I certify that (I) (this hospital) attended the deceased from <b>11</b> , 19 <b>65</b> , to <b>Oct 13</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>Oct 13</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE <b>Herbert Wisotsky</b> DEGREE <b>MD</b> ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										
22c DATE SIGNED <b>10-14-68</b>										
22d PHYSICIAN'S NAME (Type) <b>HERBERT WISOTSKY</b> 22e ADDRESS <b>101 Audley Lane, Oxon Hill</b>										
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>										
23b DATE <b>10-16-68</b>										
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>										
23d LOCATION (City or Town) (County) (State) <b>Suitland Pr. Geo. Md.</b>										
24. FUNERAL DIRECTOR <b>Wilhelm Funeral Home 4308 Suitland Rd. S. E.</b>										
25a REC'D BY REGISTRAR <b>OCT 17 1968</b>										
25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>										



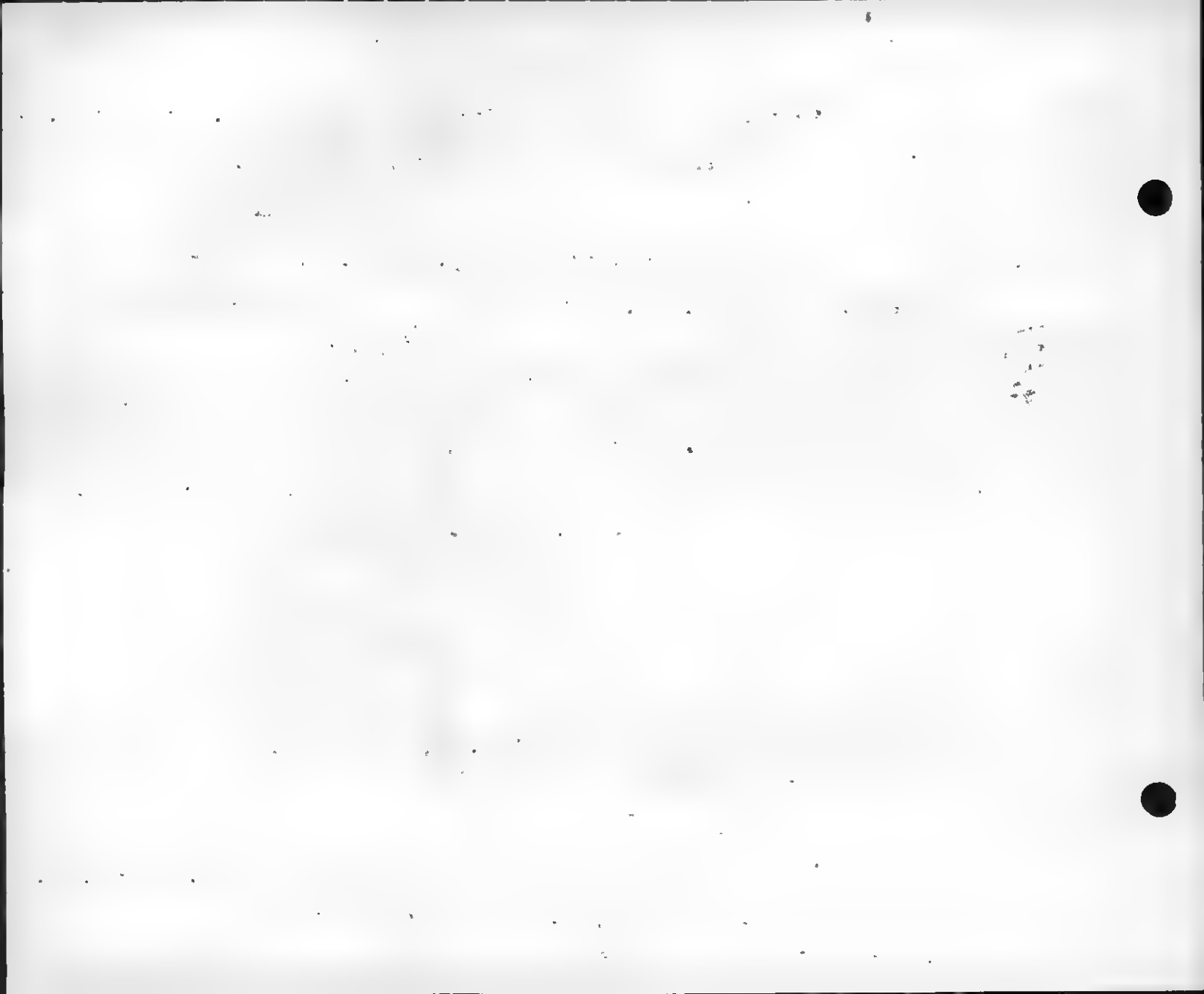
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Thereafter, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14899  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

14908

1. DECEASED-NAME (Type or print) <b>Frederick Lee</b>			2a. DATE OF DEATH Month <b>Oct.</b> Day <b>5</b> Year <b>1968</b>			2b. HOUR <b>6.30 PM</b>								
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>March 26, 1880</b>		6. AGE (In years last birthday) <b>88</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS HOURS <b>0</b> MIN <b>0</b>				
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince Georges</b> Md.								
10. CITY OR TOWN OF DEATH <b>Chesverly</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Georges Gen Hosp.</b>			12a. USUAL OCCUPATION (Kind of work done during most of workng life, even if retired) <b>Retired Soldier</b>			12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Pr. Geo.</b>			13c. CITY OR TOWN <b>Palmer Park</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>7609 Muncey Road</b>		
14. FATHER'S NAME First Middle Last <b>Isaac Lee</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Charity Mason</b>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.				17. INFORMANT <b>Joseph Lee-uncle-806 Crittenden St., NW</b>						
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>7109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (b) <b>Atherosclerotic Cerebrovascular Dis.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Concussion Head / Fainting</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 week</b> <b>years</b>										PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4221</b>				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State								
22a. I certify that <del>the</del> (this hospital) attended the deceased from <b>Sept. 21, 1968</b> to <b>Oct. 5, 1968</b> , that <del>it</del> (we) last saw the deceased alive on <b>10-5-68</b> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above: <del>it</del> (we) (did) <del>not</del> view the body after death.														
22b. SIGNATURE <b>Law</b>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>10-6-68</b>					
22d. PHYSICIAN'S NAME (Type) <b>JOHN P. STEWART</b>						22e. ADDRESS <b>Prince George's Gen'l Hosp. Chesverly, Md.</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>10/9/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Memorial Ceme.</b>			23d. LOCATION (City or Town) (County) (State) <b>Maryland</b>					
24. FUNERAL DIRECTOR <b>Stewart</b>						25a. REC'D BY REGISTRAR <b>DATE OCT 9 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					



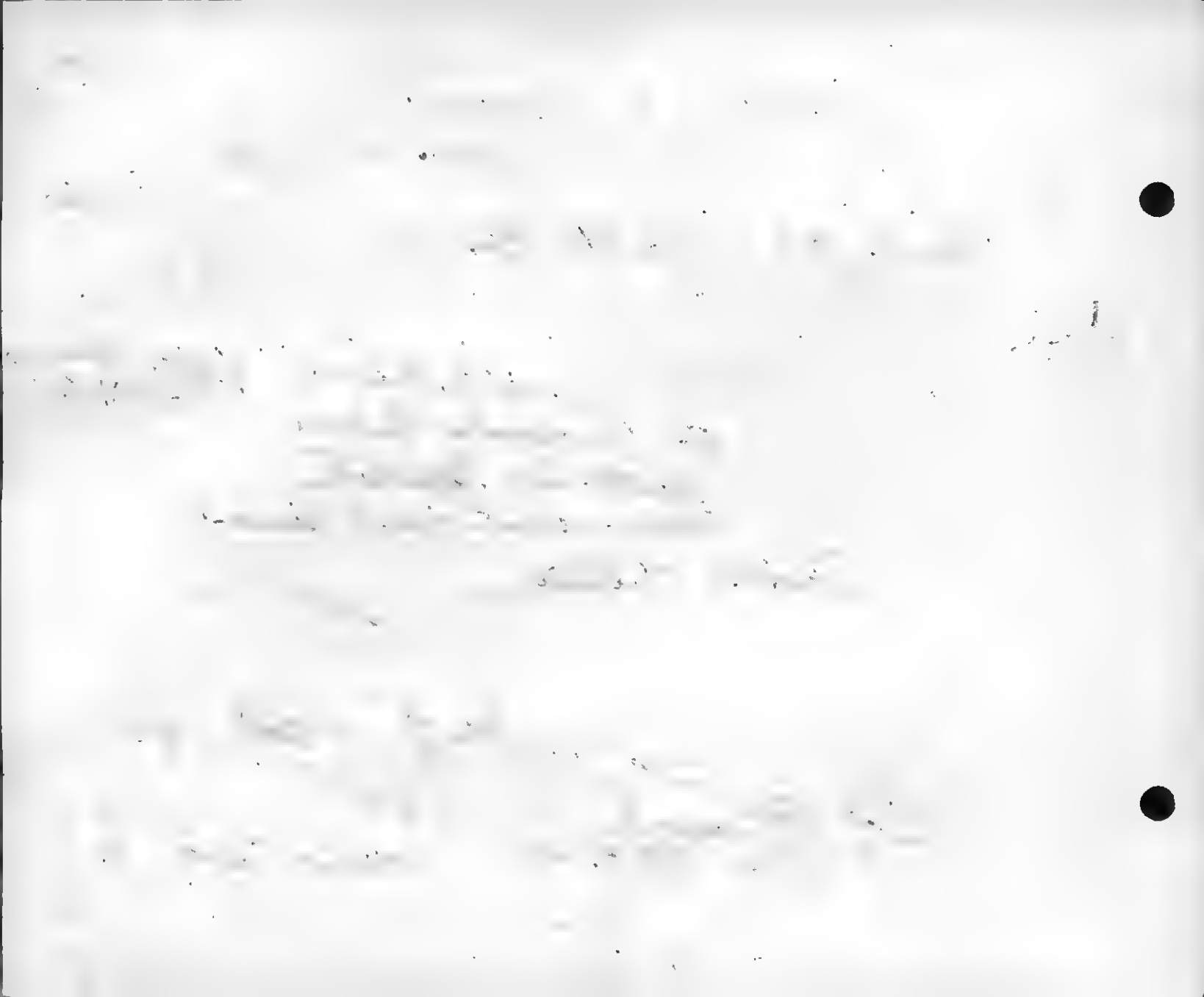
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~return~~ return carban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

VR A15  
30M REV

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) <b>ROBERT</b> First <b>D</b> Middle <b>MAHONEY</b> Last		2a. DATE OF DEATH Month <b>10</b> Day <b>7</b> Year <b>68</b> 2b. HOUR <b>5</b> MIN <b>30</b> PM	
3. SEX <b>M</b>	4 RACE <b>W</b>	5. DATE OF BIRTH <b>MAY 16, 1913</b>	6 AGE (In years last birthday) <b>55</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>WASHINGTON</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Pr. Geo.</b> Md.
10. CITY OR TOWN OF DEATH <b>Chesley Md</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Pr. Geo. Gen</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Coppersmith</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. N.Y.</b>
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>Md.</b>	13b. COUNTY <b>PRINCE GEO.</b>	13c. CITY OR TOWN <b>BELTSVILLE</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME First <b>ROBERT E.</b> Middle <b>MAHONEY</b> Last		15. MOTHER'S MAIDEN NAME First <b>MARY</b> Middle <b>PROSSER</b> Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>579-48-6716</b>	
17. INFORMANT <b>Hilda Mahoney</b>		17b. ADDRESS <b>11604 Cedar Ln. Beltsville Md 20705-7469</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Ac Myocardial Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Coronary Atherosclerotic Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Diabetes Mellitus</b>			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC	21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <b>10-6</b> 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>W.C. Etienne</b>		22c. DATE SIGNED <b>10-7-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>W.C. ETIENNE</b>		22e. ADDRESS <b>College Park Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>10/10/68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>GEORGE WASHINGTON</b>	23d. LOCATION (City or Town) (County) (State) <b>ADELPHI Md.</b>
24. FUNERAL DIRECTOR <b>F. GASCH'S SONS - Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MR ATSN  
MM REV

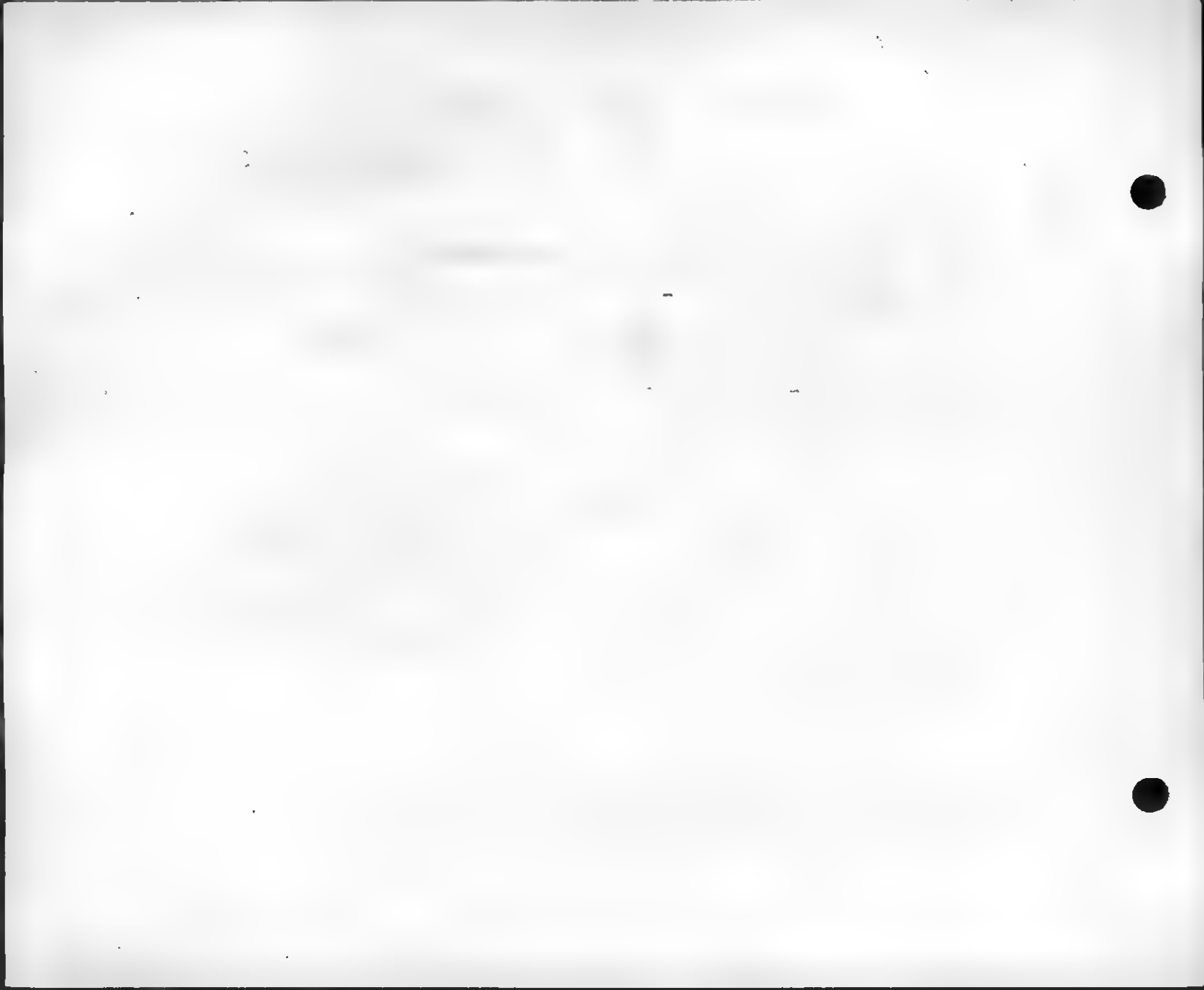
14901

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14910

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) <b>Charles F. MARKEY</b>			2a DATE OF DEATH Month <b>Oct</b> Day <b>23</b> Year <b>1968</b>			2b HOUR <b>9:15 A M</b>				
3 SEX <b>MALE</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>MAY 1, 1875</b>		6 AGE (In years last birthday) <b>93</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (State or foreign country) <b>Virginia</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George Co.</b> Md.				
10 CITY OR TOWN OF DEATH <b>Hyattsville Md.</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Hyattsville Nursing Home</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Electric Type Finisher</b>		12b KIND OF BUSINESS OR INDUSTRY				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>WASH. D.C.</b>			13b COUNTY <b>-</b>		13c CITY OR TOWN <b>WASH. D.C.</b>		13d INS. OF CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <b>2115 Monroe St. N.E.</b>	
14 FATHER'S NAME First Middle Last <b>HARRY MARKEY</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>MARY UKN</b>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO <b>578-24-5758</b>		17 INFORMANT <b>William E.-son</b>		Address <b>10405 Hutting ll., S.S.,</b>		Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b> DUE TO, OR AS A CONSEQUENCE OF <b>Cerebral Vascular Accident</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Vascular Accident</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cerebral atherosclerosis</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>mins.</b> <b>days</b> <b>years.</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			2.f LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec</b> , 1967, to <b>Oct 23</b> , 1968, that (I) (we) last saw the deceased alive on <b>10/18</b> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE <b>Harold W. Draper M.D.</b>			DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED <b>10/23/68</b>			
22d PHYSICIAN'S NAME (Type) <b>HAROLD W. DRAPER, M.D.</b>			22e ADDRESS <b>9801 GEORGIA AVE.</b>		<b>SILVER SPRING</b>					
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b DATE <b>10-26-1968</b>		23c NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		23d LOCATION (City or Town) <b>Colmar Manor, Maryland</b>		(County) (State)	
24. FUNERAL DIRECTOR <b>300 4th St. N.E. Washington D.C.</b>			25a. RECEIVED BY REGISTRAR DATE <b>OCT 28 1968</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>					





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

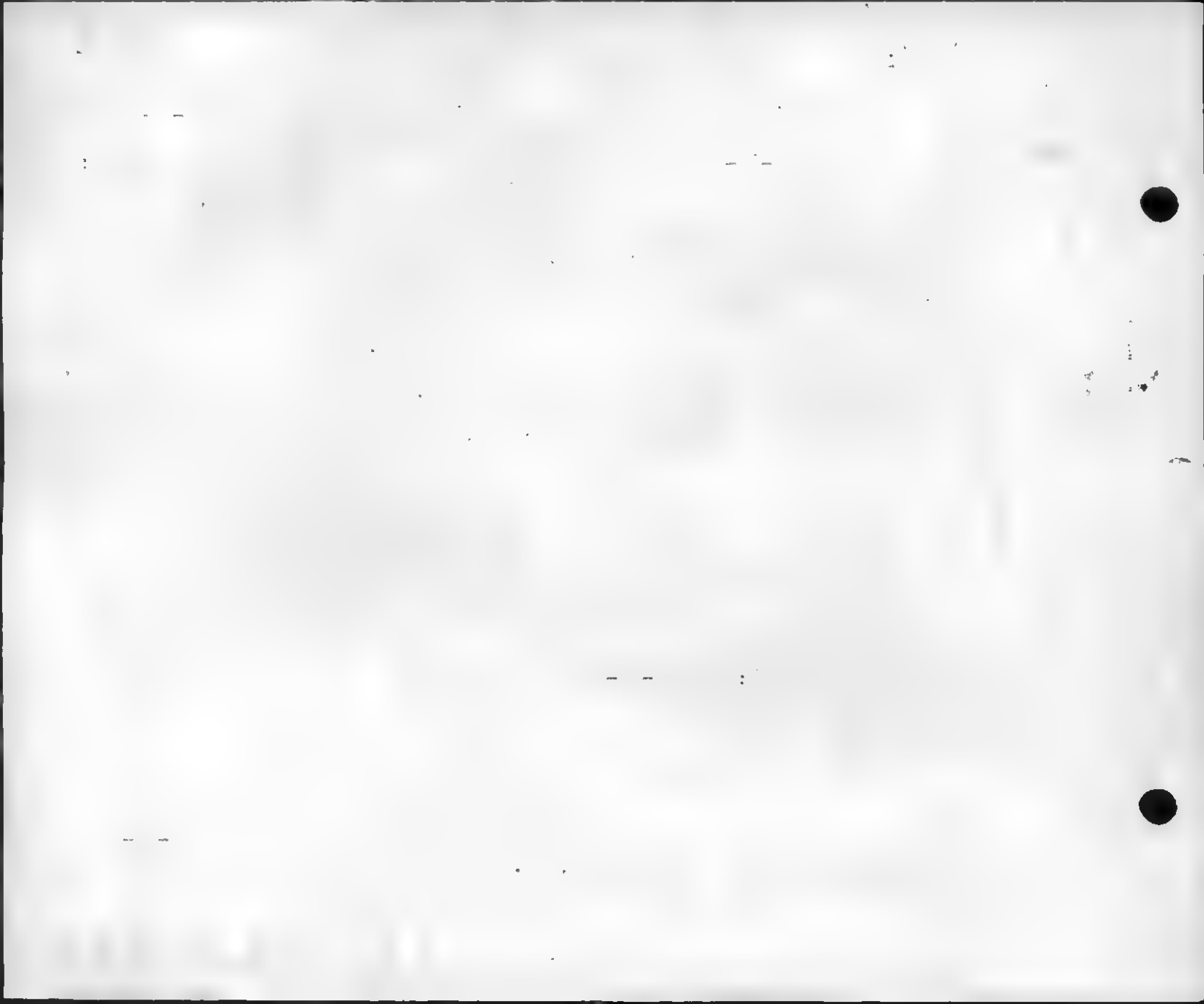
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14902

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14911

1 DECEASED-NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF DEATH Month Day Year				2b HOUR
Frederick S Martin						10-12-68 11:00am				
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	7 UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year		2d HOUR
Male	White	2-14-1906	62 YRS					10 12 68 1:27pm		M
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
Rhode Island		U S A				Prince George's				Md
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of work life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY	
Bowie			12221 Marne Lane			10rrester - Agricul			U S Gov.	
13a U.S.A. RESIDENCE (Where deceased lived, if institut on Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER			
Maryland			Prince George's		Bowie	YES <input type="checkbox"/> NO <input type="checkbox"/>	12221 Marne Lane			
14 FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
Frederic Martin			Julia R. Whyte							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT ADDRESS					
No					Bileen S. Martin 12221 Marne Lane					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gun shot wound of chest										
705 X										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										
DUE TO, OR AS A CONSEQUENCE OF (b)										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
176										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?			
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year HOUR A.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
CAUSE OF DEATH		11:00am 10-12-68		Shot self at home						
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State						
		home		Same as #13						
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED	
John Kehoe			John Kehoe MD			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			10-13-68	
			Riverdale, Md.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
						ADDRESS (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)				
Burial		10-16-68		Rawlings Cemetery		Athens Ohio				
24 FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Wilhelm Funeral Home 4308 Suitland Rd. S. E.			Wash. D. C.			DATE OCT 17 1968		Charles Judge		



FOR STATE  
HEALTH DEPT.

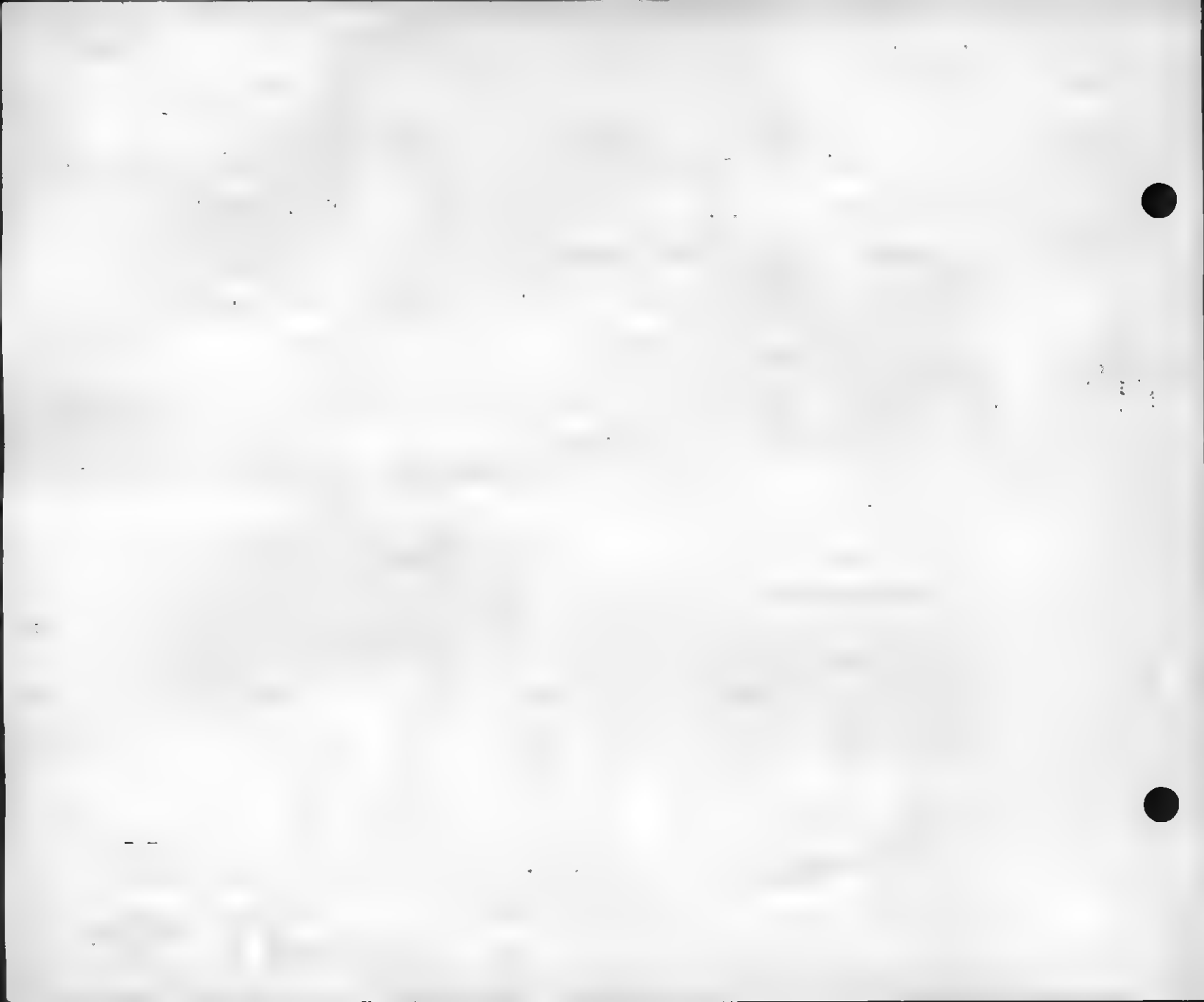
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14903

14912

1. DECEASED NAME (Type or Print) First Middle Last <b>Gertrude S Mathews</b>			2a. DATE KNOWN OF DEATH Month Day Year <b>10-7-68</b>			2b. HOUR 12:20 PM		
3 SEX <b>Female</b>	4 RACE <b>Negro</b>	5 DATE OF BIRTH <b>3-27-1900</b>	6 AGE (in years last birthday) <b>68</b> YRS	7 UNDER 1 YEAR MONTHS DAYS HOURS MIN	8 IF UNDER 24 HRS	2c. DATE PRONOUNCED DEAD Month Day Year <b>10 7 68</b>		
7a. BIRTHPLACE (State or foreign country) <b>HOWARD CO. MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George's</b> Md.		
10 CITY OR TOWN OF DEATH <b>Cheverly</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince George Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) - STATE <b>Maryland</b>		13b. COUNTY <b>Laurel</b>		13c. CITY OR TOWN <b>Laurel</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>502 9th. Street</b>
14 FATHER'S NAME First Middle Last <b>EDWARD BROOKS</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>KATHERINE HOWARD</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO (If yes give war or dates of service)		17. INFORMANT <b>MRS CATHERINE BURLEY</b>			ADDRESS <b>LAUREL, MD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO, OR AS A CONSEQUENCE OF <b>Arteriosclerotic heart disease</b> (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes unknown</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>426</b>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <b>John Kehoe MD</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <b>10-8-68</b>		
EXAMINER'S NAME (Type) <b>John Kehoe MD Riverdale, Md.</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>10-11-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>QUEENS CHAPEL CEM.</b>		23d. LOCATION (City or Town) (County) (State) <b>MURKIRK, PR GRGS, MD</b>	
24. FUNERAL DIRECTOR <b>Robert L. Snowden Rockville, Md</b>				25a. REC'D BY REG STRAR <b>OCT 14 1968</b>		25b. RECORDED & INDEXED <b>10-8-68</b>		



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
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14904  
Item 106, Film 3406

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14913

1. DECEASED NAME (Type or Print) First Edward Middle L Last McCormack			2a. DATE KNOWN OF DEATH Month 10 Day 26 Year 68 1911			2b. HOUR 30am							
3 SEX Male		4 RACE White		5 DATE OF BIRTH 11-30-1913		6 AGE (In years last birthday) 54 1/2 YRS		7c. DATE PRONOUNCED DEAD Month 10 Day 26 Year 68 1912		2d. HOUR 40pm			
7a. BIRTHPLACE (State or foreign country) Va.			7b. CITIZEN OF WHAT COUNTRY? U S A			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Prince George's Md.				
10. CITY OR TOWN OF DEATH Cheverly				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital				12a. USUAL OCCUPATION (Kind of work done during most of work no life even if retired) Retired machinist				12b. KIND OF BUSINESS OR INDUSTRY U S Government	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland				13b. COUNTY Prince George's				13c. CITY OR TOWN Hyattsville				13d. INSIDE CITY L & M IS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME First Edward Middle Mc Cormack Last				15 MOTHER'S MAIDEN NAME First Mae Middle Beasley Last									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16b. SOCIAL SECURITY NO (If yes give war or dates of service) 212 07 2658				17 INFORMANT Ruth E Mc Cormack				ADDRESS Hyattsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Occlusion of coronary artery DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: minutes over 9 yrs			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe MD						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) Riverdale, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE Oct 29, 1968		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery				23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.			
24. FUNERAL DIRECTOR F. Gasch's Sons						ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE OCT 31 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 B

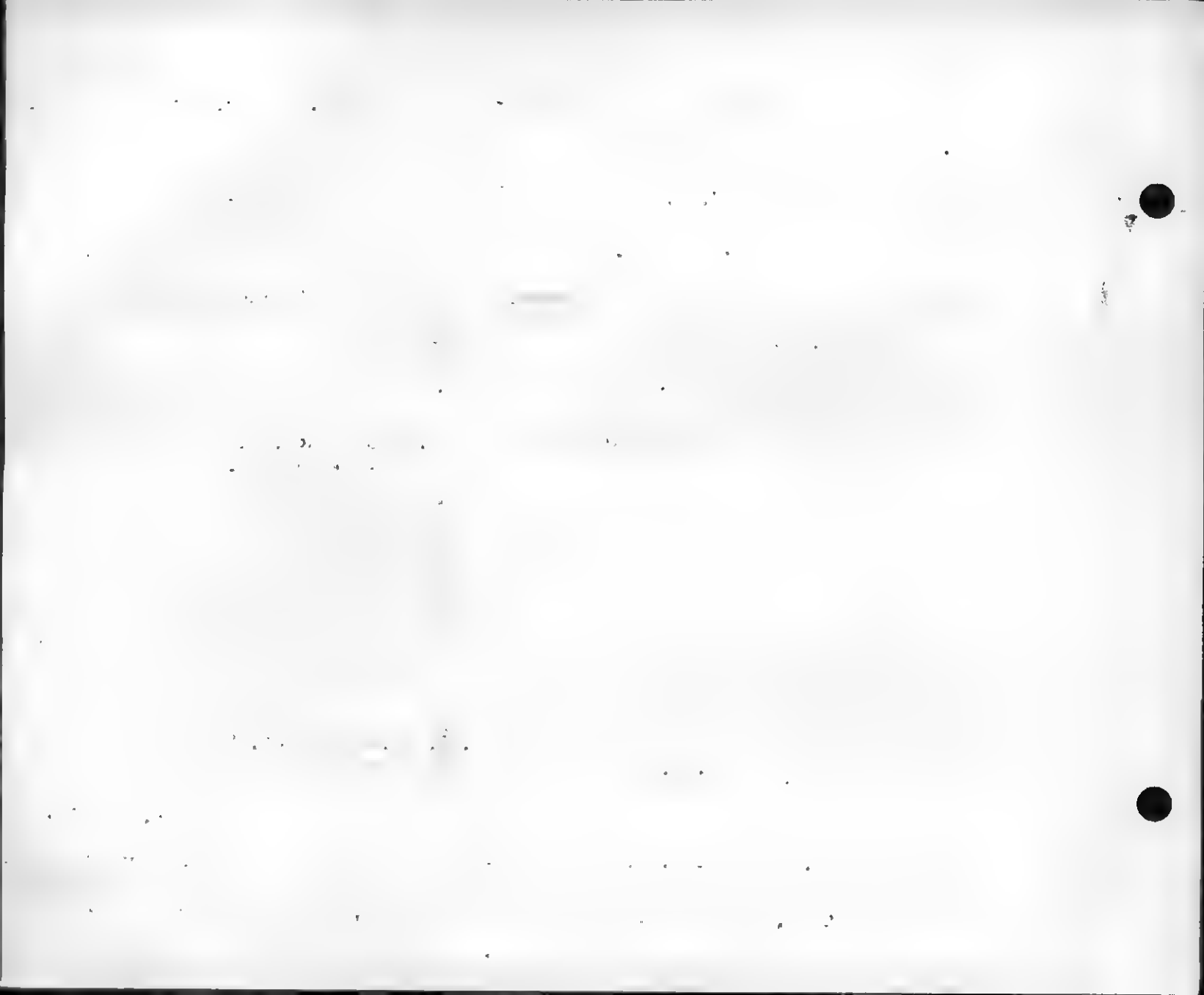
14905

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14914

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR				
Richard J McGarry						Oct. Month 8, Day 1968 Year			8 P.M.				
3 SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		Caucasian		3/4/15		55 YRS		MONTHS DAYS		HOURS MIN			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH							
New Jersey		U. S. A.				Prince George's Md							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY				
Cheverly			Prince Geo. Gen'l Hospital			Presser			cloths				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admiss on) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER				
New Jersey					Paterson				31A Alabama Avenue				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME										
First Middle Last			First Middle Last										
Thomas Mc Garry			Rose Kelley										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) Yes			16b. SOCIAL SECURITY NO. W W 11		17. INFORMANT		Address						
			143 07 8537		Regina McGarry		Paterson N. J.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Bilateral Bronchial Pneumonia, acute, with abscess formation.</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (this hospital) attended the deceased from <u>Sept. 2, 1968</u> , to <u>Oct. 8, 1968</u> , that (we) last saw the deceased alive on <u>Oct. 8, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>V. Charles</u>								DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED Oct. 9, 1968	
22d. PHYSICIAN'S NAME (Type) V. Charles, M. D.				22e. ADDRESS Prince George's General Hospital, Cheverly, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Oct 12, 1968		23c. NAME OF CEMETERY OR CREMATORY Holy Sepulchre Cemetery		23d. LOCATION (City or Town) (County) Totowa-Boro Passais N J.							
24. FUNERAL DIRECTOR F. Gasch's Sons				ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE OCT 14 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge					

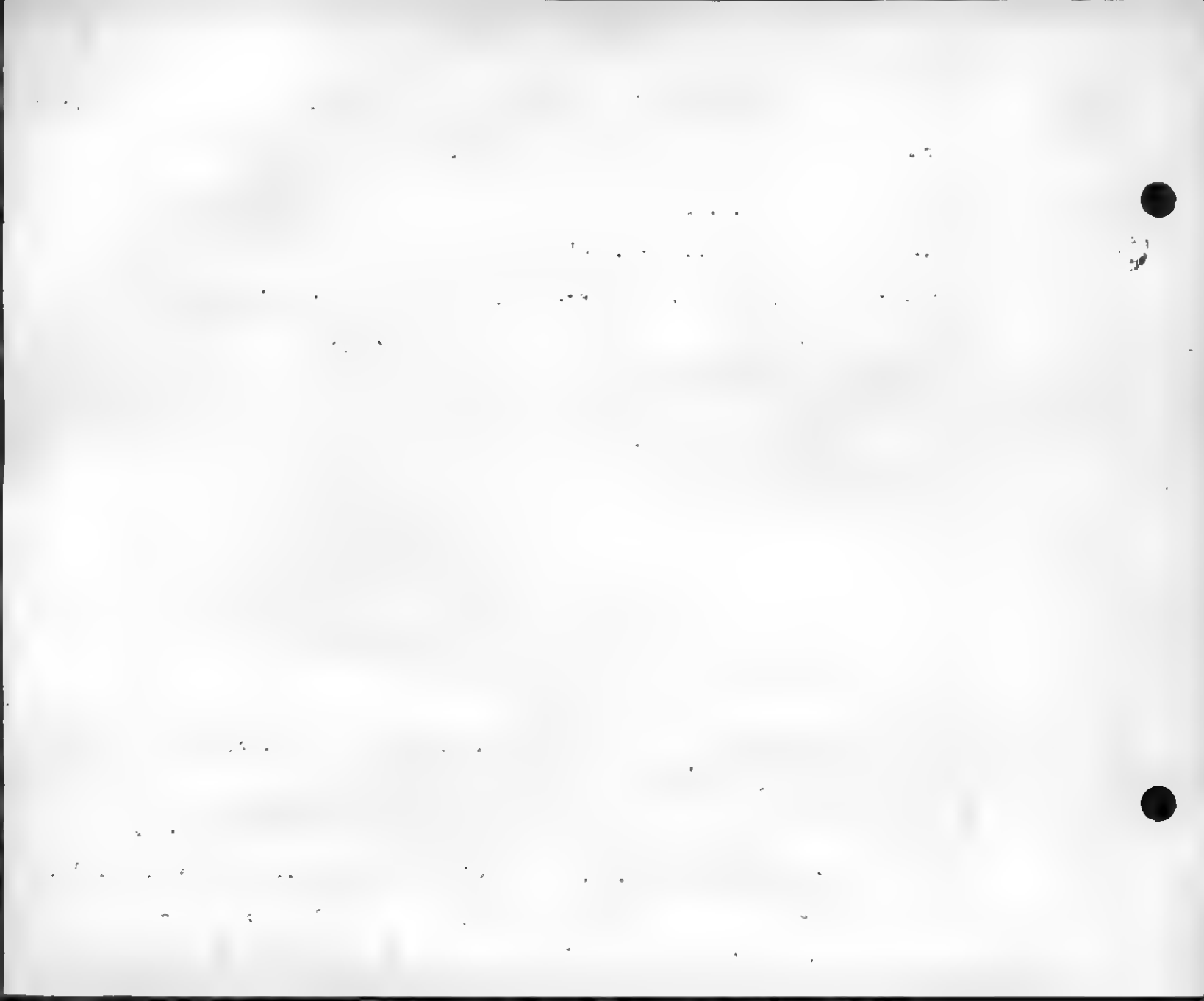




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <b>Kathleen</b>		First <b>Baby</b> Middle <b>Marie</b> Last <b>McGehee</b>		2a. DATE OF DEATH <b>Oct. Month 9, Day 1968</b>		2b. HOUR <b>7:50PM</b>			
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>Oct. 9, 1968</b>		6. AGE (In years last birthday) <b>YRS</b>		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George's Md</b>			
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo. Gen'l Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. CITY <b>Prince George's</b>		13c. CITY OR TOWN <b>Hyattsville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>6611 24th Place</b>	
14. FATHER'S NAME First Middle Last <b>Milton Manuel McGehee</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Linda Anne Fowler</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO (If yes give war or dates of service)		17. INFORMANT		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>771X mortid prematurity</b> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>Oct. 9, 1968</b> , to <b>Oct. 9, 1968</b> , that (I) <del>(we)</del> saw the deceased alive on <b>Oct. 9, 1968</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> <del>(did)</del> view the body after death.									
22b. SIGNATURE <b>[Signature]</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>Oct. 11, 1968</b>			
22d. PHYSICIAN'S NAME (Type) <b>Radji Mahdavi, M. D.</b>				22e. ADDRESS <b>6821 Riverdale Rd., Riverdale, Md. 20840</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>10/26/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Prince Geo. General Hospital</b>		23d. LOCATION (City or Town) (County) (State) <b>Cheverly, Maryland</b>			
24. FUNERAL DIRECTOR <b>William A. Parker, Assoc. Administrator</b>				ADDRESS		25a. REC'D BY REGISTRAR DATE <b>OCT 29 1968</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

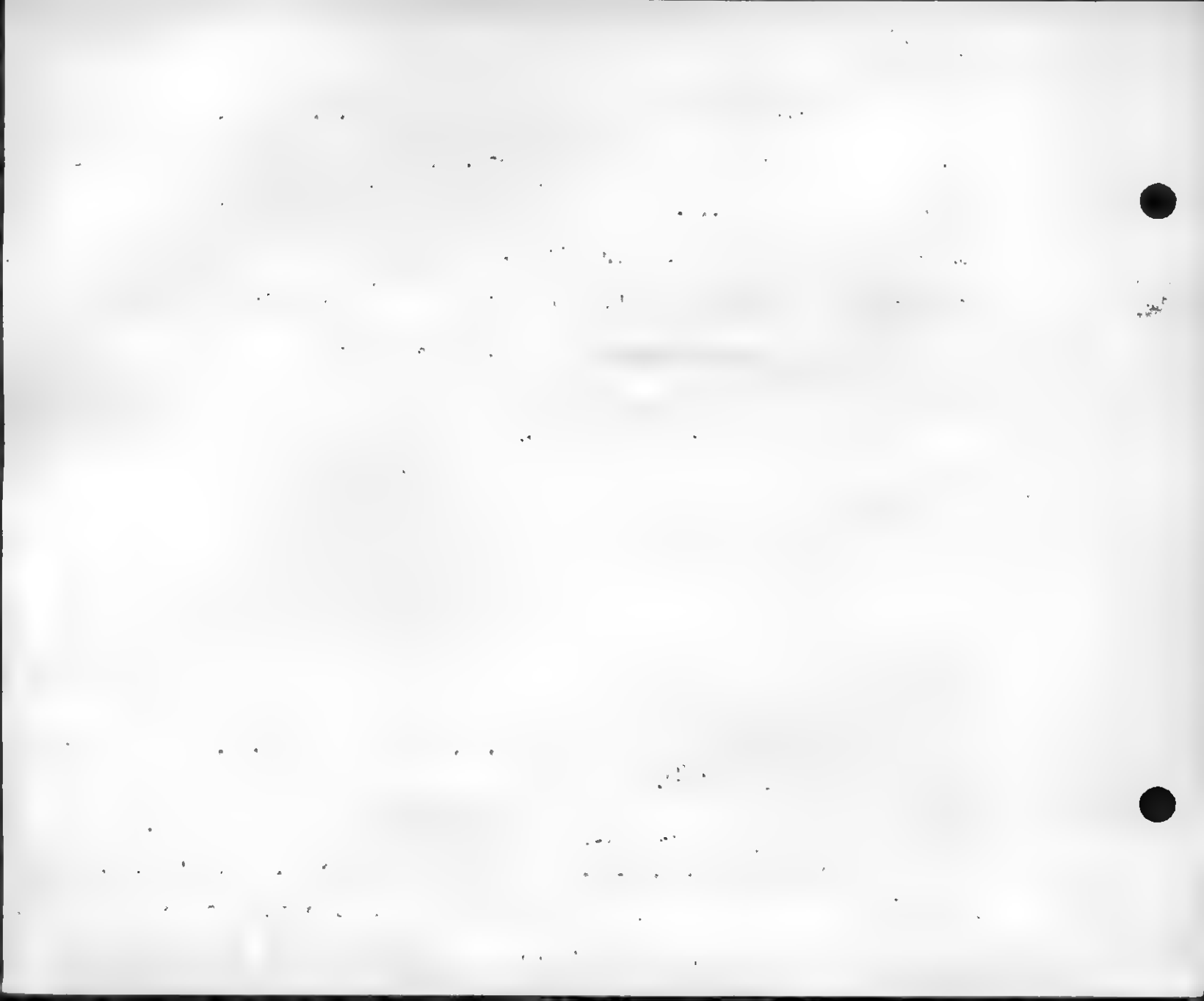
14916

14907  
Item File 158,4/69 kk

1 DECEASED NAME (Type or print) <b>Virconia Lynn</b>			First Middle Last			2a. DATE OF DEATH Month <b>9</b> Day <b>9</b> Year <b>1968</b>			2b. HOUR <b>8:20PM</b>		
3 SEX <b>Female</b>			4 RACE <b>Caucasian</b>			5 DATE OF BIRTH <b>Oct. 9, 1968</b>			6. AGE (In years last birthday) YRS. MONTHS DAYS		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>US..A.</b>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Prince George's</b> Md.		
10 CITY OR TOWN OF DEATH <b>Cheverly</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo.Gen'l HOsptial</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Prince George's</b>			13c. CITY OR TOWN <b>Hyattsville</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First Middle Last <b>Milton Manuel McGehee</b>			15 MOTHER'S MAIDEN NAME First Middle Last <b>Linda Anne Fowler</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes, na, or unknown			16b. SOCIAL SECURITY NO.		
17. INFORMANT Address			18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Marked prematurity</b> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>776</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) <b>(this hospital)</b> attended the deceased from <b>Oct. 9, 1968</b> , to <b>Oct. 8, 1968</b> , that (I) <b>(we)</b> last saw the deceased alive on <b>Oct. 9, 1968</b> , and that in (my) <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above, (I) <b>(we)</b> <b>(did)</b> <b>(didn't)</b> view the body after death.											
22b. SIGNATURE <b>Iradji Mahadavi, M. D.</b>			DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>Oct. 11, 1968</b>					
22d. PHYSICIAN'S NAME (Type) <b>Iradji Mahadavi, M. D.</b>			22e. ADDRESS <b>6821 Riverdale Rd., Riverdale, Md. 20840</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE <b>10/26/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Prince Geo. General Hosp.</b>			23d. LOCATION (City or Town) (County) (State) <b>Cheverly, Maryland</b>		
24 FUNERAL DIRECTOR <b>William A. Parker, Assoc. Administrator</b>			25a. REC'D BY REGISTRAR DATE <b>OCT 29 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. One Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-1. Page 5 may be retained for your files.

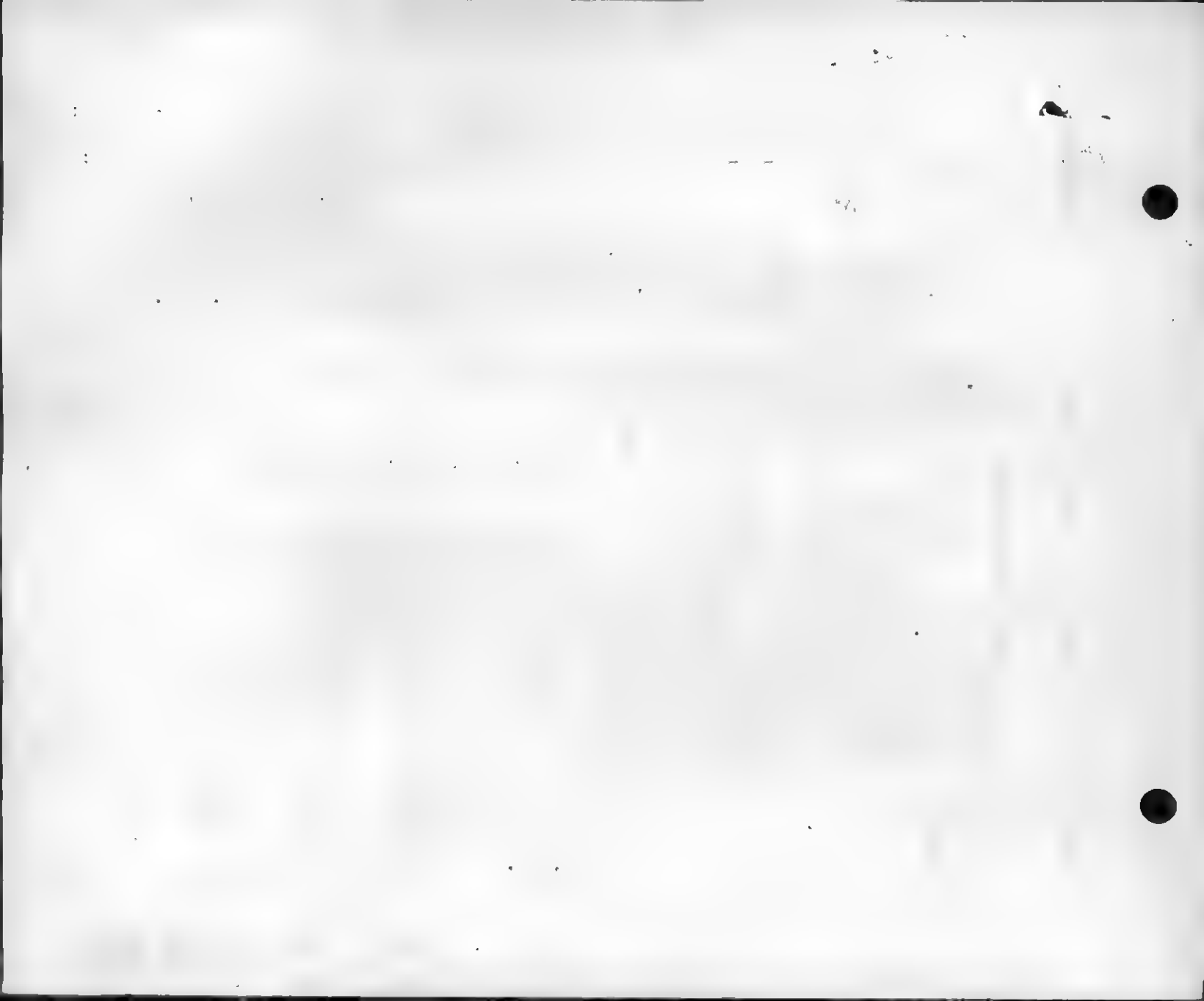
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14908

**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

14917

1. DECEASED-NAME (Type or Print) First Middle Last George M McSweeney			2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 10-22-68 19 4:45pm		2b. HOUR
3 SEX Male	4 RACE White	5 DATE OF BIRTH 2-25-1912	6. AGE (In years last birthday) 56 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country) ALABAMA		7b CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince George's Md
10 CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) RETIRED MARINE	
13a USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) STATE Maryland		13b COUNTY Prince George's		13c CITY OR TOWN Bladensburg	13d INSIDE CITY LIM 157 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME First Middle Last UNKNOWN		15 MOTHER'S MAIDEN NAME First Middle Last UNKNOWN			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16b. SOCIAL SECURITY NO (If yes give year or dates of service) RETIRED USMC 57718 3958		17 INFORMANT MARGUERITE P. MCSWEENEY ADDRESS MENLO, IOWA,	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease over 3 yrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4220					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or RFD No City or Town County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe MD		M.D. Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE 10-26-1968	23c NAME OF CEMETERY OR CREMATORY STUART CEMETERY		23d LOCATION (City or Town) (County) (State) STUART IOWA.
24 FUNERAL DIRECTOR W.W. CHAMBERS Co. RIVERDALE, MARYLAND		25a. FILED BY REG STRAR DATE OCT 28 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print)			First		Middle		Last		2a DATE OF DEATH Month Oct Day 11, 1968		
Robert			H		Melvin		sr.		2b. HOUR M		
3. SEX male			4. RACE white			5. DATE OF BIRTH April 16, 1891			6. AGE (In years last birthday) 77 YRS.		
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Prince George's Md		
North carolina			U S A								
10 CITY OR TOWN OF DEATH Cheverly			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Auto Dealer			12b KIND OF BUSINESS OR INDUSTRY Automobiles		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md			13b. COUNTY Pro George's			13c. CITY OR TOWN Bladensburg			13d INSIDE CITY LIM TST YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e STREET AND NUMBER 4200 53 Place Apt #1											
14. FATHER'S NAME First Middle Last Daniel H Melvin					15. MOTHER'S MAIDEN NAME First Middle Last Martha E Furmidge						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no			16b. SOCIAL SECURITY NO (If yes give war or dates of service) 578 01 5256			17 INFORMANT Address Lillian H. Melvin Bladensburg, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CARCINOMA of PANCREAS 10-17 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 157X (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Arteriosclerotic Heart Disease											
19a. DATE OF OPERATION 10-10-68			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CARCINOMA of PANCREAS			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify med cal examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 10-2-1968, to 10-12-1968, that (I) (we) last saw the deceased alive on 10-11-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE A. Deitz M.D.						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 10-12-68		
22d. PHYSICIAN'S NAME (Type) A Deitz						22e. ADDRESS Pro Geo Plaza Hyattsville, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE Oct 15, 1968			23c. NAME OF CEMETERY OR <del>CHURCH</del> Friendship Methodist church			23d. LOCATION (City or Town) (County) (State) Friendship Calvert Md		
24. FUNERAL DIRECTOR F. Gasch's Sons						ADDRESS Hyattsville, Md.			25a. REC'D BY REGISTRAR DATE OCT 14 1968		
									25b. REGISTRAR'S SIGNATURE Charles Judge		

MEDICAL CERTIFICATION





14910

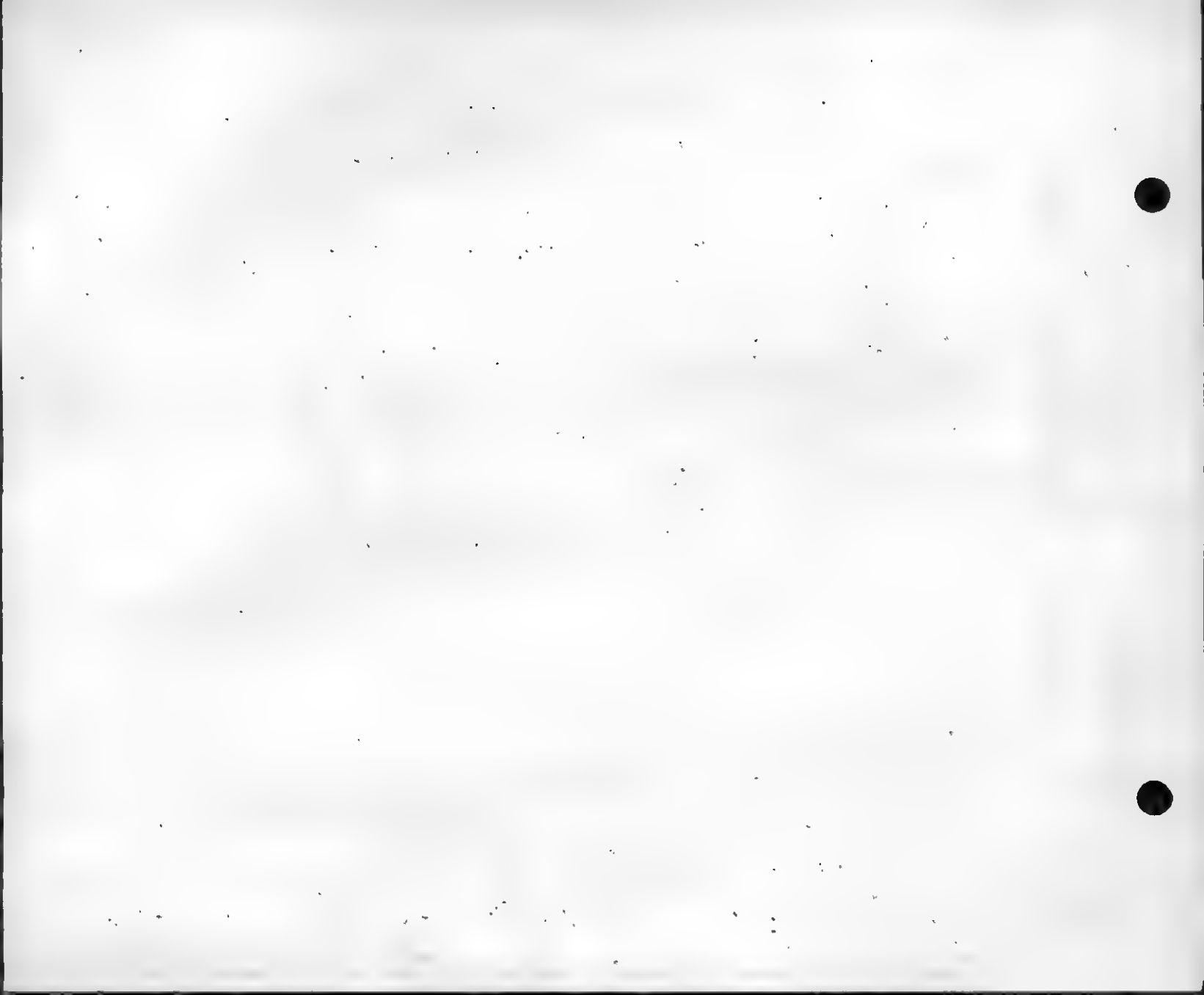
14919

## CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) <b>HELEN MAE MERSON</b>			2a. DATE OF DEATH Month <b>Oct</b> Day <b>31</b> Year <b>1968</b>			2b. HOUR M				
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>March 23 1906</b>		6. AGE (In years last birthday) <b>62 YRS</b>		7. UNDER 24 HRS. MONTHS DAYS HOURS M.H.		
7a. BIRTHPLACE (State or foreign country) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George</b> Md				
10. CITY OR TOWN OF DEATH <b>Laurel</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>1009 WARD ST</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>house</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Md</b>			13b. COUNTY <b>PG</b>		13c. CITY OR TOWN <b>Laurel</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>1009 WARD ST.</b>	
14. FATHER'S NAME First Middle Last <b>Harace Johnson</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Susie Dennis</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			16b. SOCIAL SECURITY NO			17. INFORMANT <b>Joan Mereson</b>			Address <b>Laurel Md</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes and Hypo thyroidism</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that (I) (the hospital) attended the deceased from <b>Jan</b> , 19 <b>67</b> , to <b>Oct</b> , 19 <b>68</b> , that (I) (we) lost saw the deceased alive on <b>Oct 30</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE <b>Arnold J. Brody</b>			DEGREE			ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>1 Nov 68</b>		
22d. PHYSICIAN'S NAME (Type) <b>ARNOLD BRODY</b>			22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>11-3-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Trinity Hill Cem</b>		23d. LOCATION (City or Town) <b>Laurel Md</b>		(County) (State)	
24. FUNERAL DIRECTOR <b>Donnellan Funeral Home</b>			ADDRESS <b>Laurel Md</b>			25a. REC'D BY REGISTRAR <b>NOV 8 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

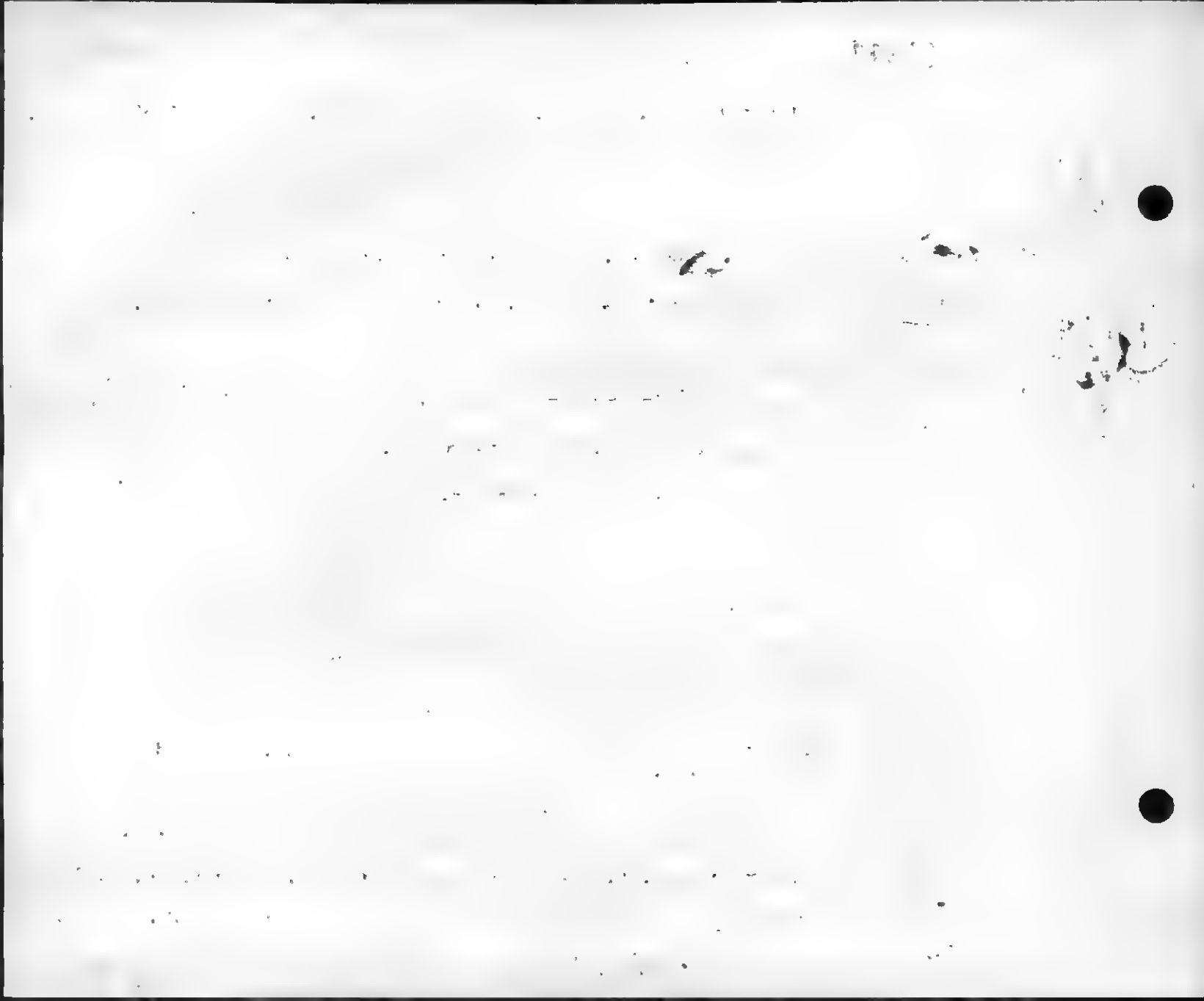
14911

14921

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First Middle Last <b>James T. Millard</b>			2a. DATE OF DEATH Month Day Year <b>Oct. 8, 1968</b>		2b. HOUR <b>4 P.M.</b>
3. SEX <b>Male</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH <b>August 12, 1900</b>		6. AGE (In years lost birthday) <b>68</b> YRS.	7. UNDER YEAR MONTHS DAYS 8. UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Prince George's</b> Md.		
10. CITY OR TOWN OF DEATH <b>Cheverly</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>DOA Prince Geo.Gen'l Hospital</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>carpenter</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Maryland</b>	13b. COUNTY <b>Prince George's</b>	13c. CITY OR TOWN <b>Upper Marlboro</b>	13d. INSIDE CITY LIMITS? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>	13e. STREET AND NUMBER <b>2209 Sansbury Rd.</b>	
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. <b>577-30-3533-A</b>		17. INFORMANT Address <b>Dewitt T. Gallahan 2209 Stansbury Rd. Upper Marlboro Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. <b>4339</b> IMMEDIATE CAUSE (a) <b>Acute Cerebellar Infarction.</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Right Bronchopneumonia.</b> DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>30 x x</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) <del>(this hospital)</del> attended the deceased from <b>7-11</b> , 19 <b>68</b> , to <b>Oct. 8, 1968</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>Oct. 8, 1968</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> <b>(did not)</b> view the body after death.					
22b. SIGNATURE <b>Oliver B. Bond</b> M.D.				22c. DATE SIGNED <b>Oct. 9, 1968</b>	
22d. PHYSICIAN'S NAME (Type) <b>Oliver Bond, M. D.</b>				22e. ADDRESS <b>6872 Riverdale Rd., Lanham, Md. 20801</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>Oct. 12, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Epiphany</b>	
23d. LOCATION (City or Town) (County) (State) <b>Forestville, P.G. Md.</b>		24. FUNERAL DIRECTOR ADDRESS <b>Matthews 131-11th St. S.E.</b>			
25a. REC'D BY REGISTRAR DATE <b>OCT 14 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

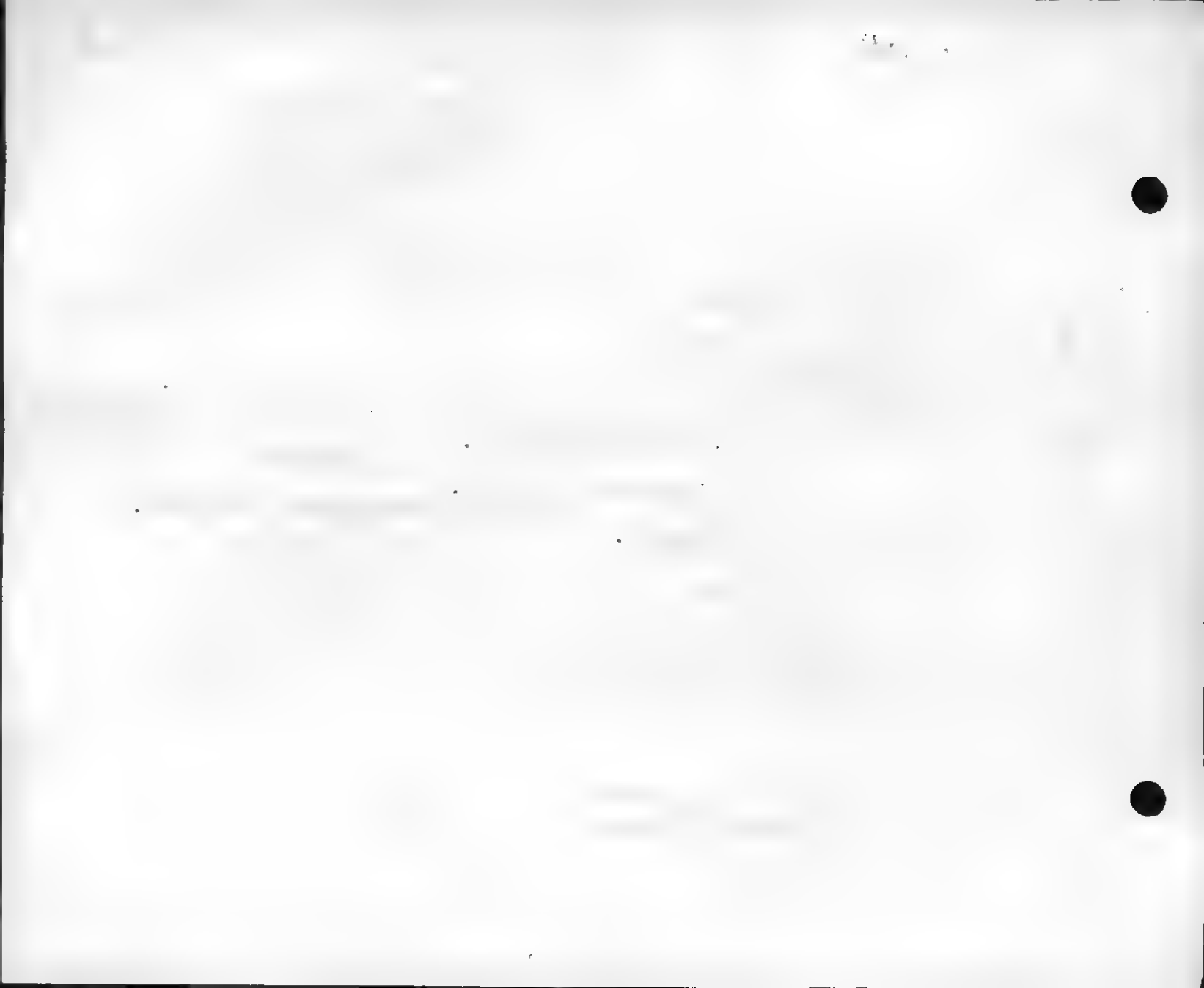
14910

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14922

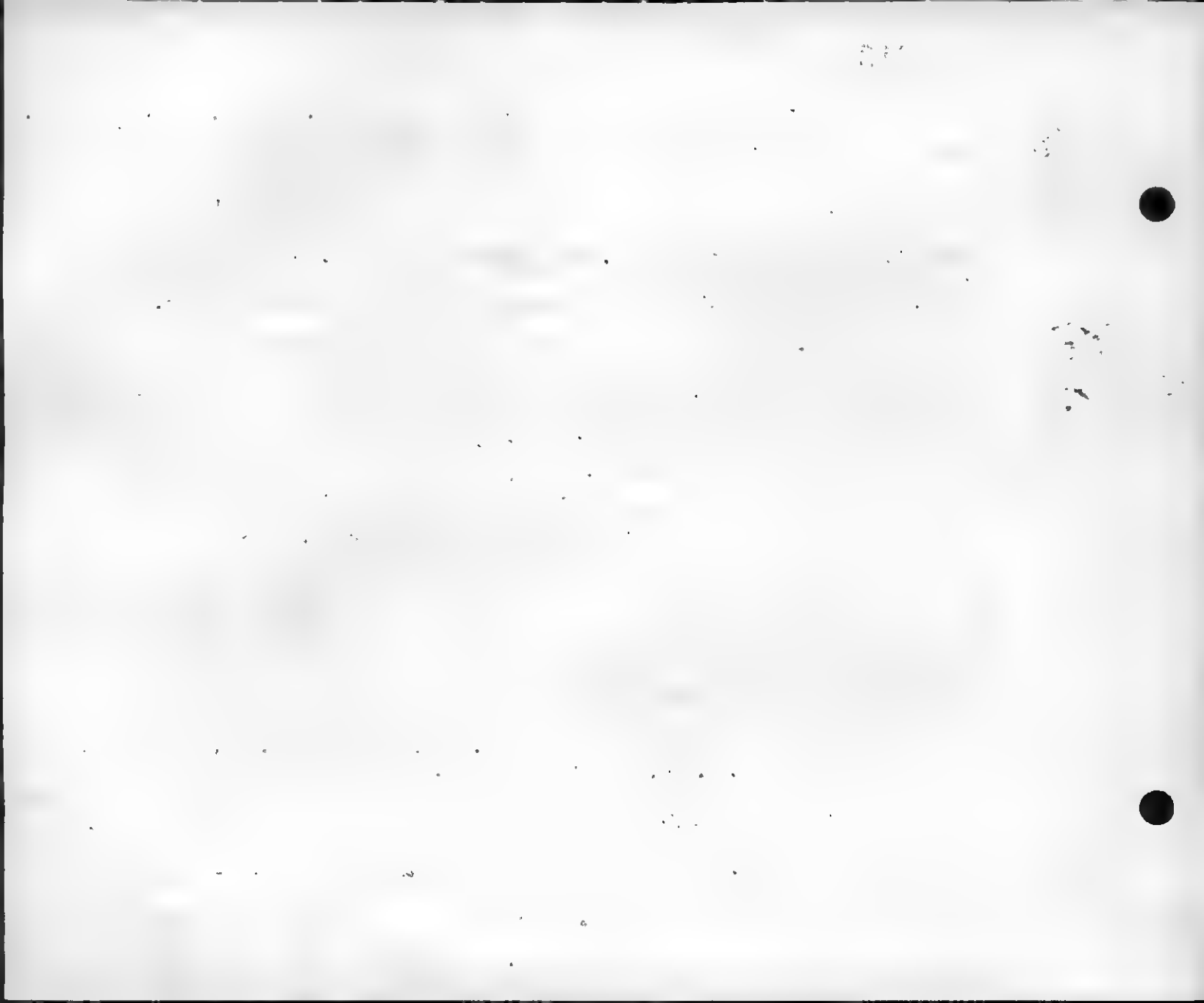
1. DECEASED-NAME (Type or print)		First Middle Last		2a. DATE OF DEATH		2b. HOUR	
Eunice Catherine Millwood				Month Day Year Oct. 17, 1968		1:30 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	
Female		Caucasian		8/27/07		61 YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
South Carolina		U S A				Prince George's Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly		Prince George's General		Heaver		Textile	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md		Pro Geo		Hyattsville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER		14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
5511 43rd place		First Middle Last ? Childers		First Middle Last Nettie Pettie			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT		Address	
no		247-07-6290		Robert J Mead		Hyattsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>and Broncho-pneumonia.</u>							
DUE TO, OR AS A CONSEQUENCE OF <u>Cancer of the right lung with</u>							
(b) <u>wide-spread metastasis.</u>							
DUE TO, OR AS A CONSEQUENCE OF <u>Generalized Arteriosclerosis indicated.</u>							
(c) <u>Cachexia.</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION							
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							
20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)							
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19							
21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>							
21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)							
21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>9/26</u> , 19 <u>68</u> , to <u>10/17</u> , 19 <u>68</u> , that (I) (we) lost the deceased alive on <u>10/17</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>[Signature]</u> DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>							
22c. DATE SIGNED							
22d. PHYSICIAN'S NAME (Type) <u>Dr. Ohannes Sahakyan</u>							
22e. ADDRESS <u>6001 Landover Rd., Cheverly, Md. 20785</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>							
23b. DATE <u>Oct 20, 1968.</u>							
23c. NAME OF CEMETERY OR CREMATORY <u>Clifton Cemetery</u>							
23d. LOCATION (City or Town) (County) (State) <u>Clifton S C</u>							
24. FUNERAL DIRECTOR <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Md</u>							
25a. RECD BY REGISTRAR <u>OCT 21 1968</u>							
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
14913						14923					
1. DECEASED-NAME (Type or print)			First John Middle Last Moniz			2a. DATE OF DEATH Month 16, Day 1968 Year			2b. HOUR 10 A.M.		
3 SEX Male			4 RACE Caucasian			5. DATE OF BIRTH March 8 1914			6 AGE (in years lost today) 54 YRS.		
7a. BIRTHPLACE (State or foreign country) New York			7b. CITIZEN OF WHAT COUNTRY? U S A			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Prince George's Md.		
10. CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen'l Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Crain operator			12b. KIND OF BUSINESS OR INDUSTRY Salvage Co		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE New York			13b. COUNTY Kings			13c. CITY OR TOWN Brooklyn			13d. INSIDE CITY LIM TS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First Middle Last Gabriael Moniz			15. MOTHER'S MAIDEN NAME First Middle Last Angelina Pachio			13e. STREET AND NUMBER 728 Leffets St.					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown			16b. SOCIAL SECURITY NO. 052 12 0393			17 INFORMANT Hospital records			Address Cheverly, Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Cardiac Tamponade</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Arteriosclerotic Heart Disease</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>None</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <del>(H)</del> (this hospital) attended the deceased from <u>Oct. 10, 1968</u> , to <u>Oct. 16, 1968</u> , that <del>(H)</del> (we) last saw the deceased alive on <u>Oct. 16, 1968</u> , and that in <del>(my)</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>(H)</del> (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Herrandez</u>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22c. DATE SIGNED <u>10/16/68</u>		
22d. PHYSICIAN'S NAME (Type) <u>T. J. HERRANDEZ MD</u>						22e. ADDRESS <u>PRINCE GEO. GEN. HOSP. Bldg</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE <u>Oct 19, 1968</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Pine Lawn Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Long Island Queens N Y</u>		
24. FUNERAL DIRECTOR ADDRESS <u>F. Gasch's Sons Hyattsville, Md.</u>						25a. REC'D BY REGISTRAR DATE <u>OCT 21 1968</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

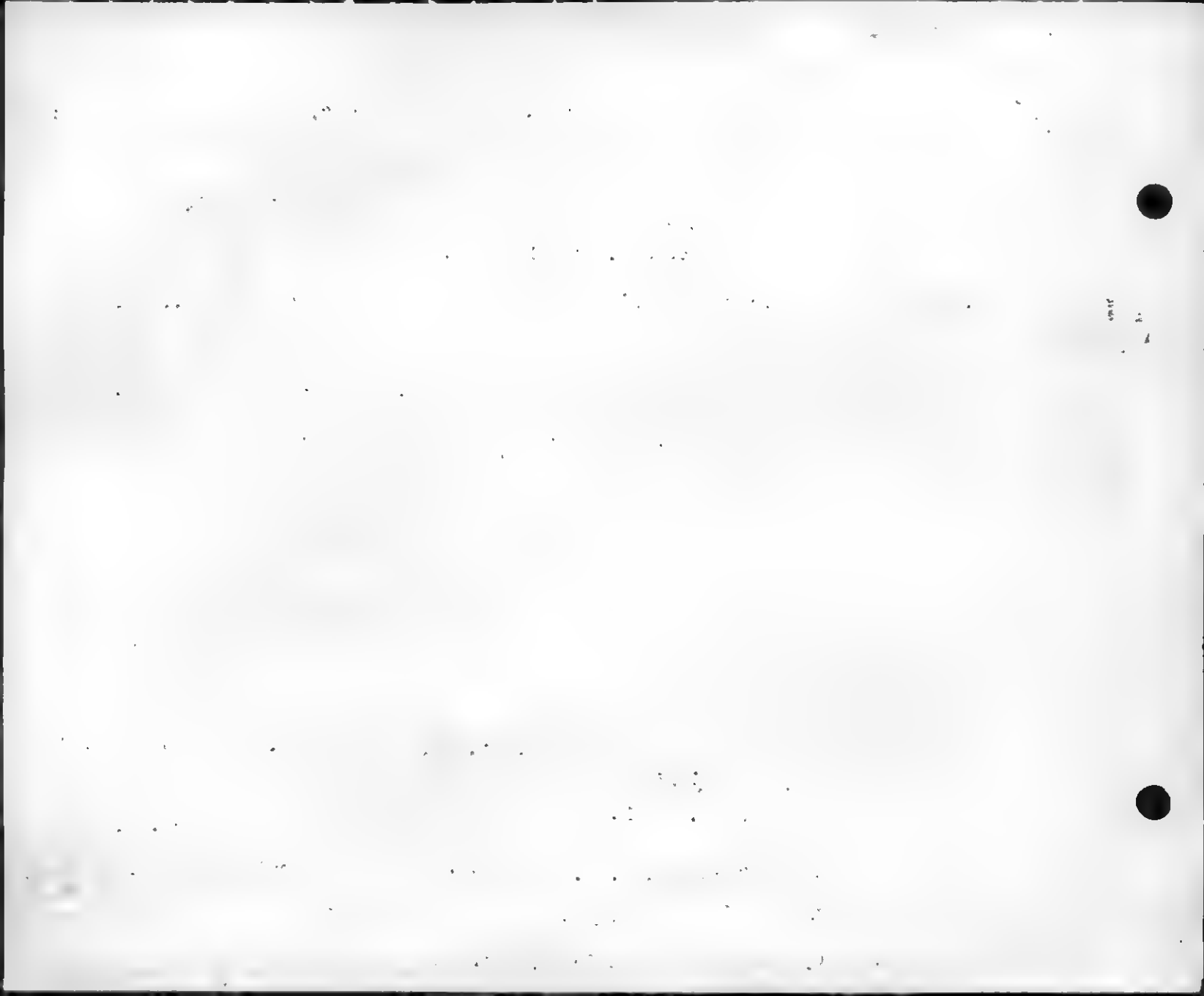




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>14914</div> <div>Item 23 Film G405 10/21/68 kk</div>										<div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div>										<div>14924</div>																																																											
1. DECEASED NAME (Type or print)										First										Middle										Last										2a. DATE OF DEATH										2b. HOUR																													
Josephine										Moore																				Oct.										Month 10, Day 1968										10:30 <sup>A</sup>																													
3 SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years lost birthday)										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS HOURS MIN																													
Female										Negro										Dec 9, 1912										55																																																	
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH																																																	
Va										U S A																				Prince George's										Md.																																							
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)										12b. KIND OF BUSINESS OR IND. STRY																																																	
Cheverly										Prince Geo. Gen'l Hospital										Domestic										housework																																																	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER																																							
Maryland										Prince George's										Deanwood Pk																				5010 Nash St., NE.																																							
14. FATHER'S NAME										First										Middle										Last										15. MOTHER'S MAIDEN NAME										First										Middle										Last									
Robert Banks																																								Harriett Jones																																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO										(If yes give war or dates of service)										16b. SOCIAL SECURITY NO										17. INFORMANT										Address																																							
																				230 38 5401										Hospital records										Cheverly, Md.																																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										PART 1 DEATH WAS CAUSED BY:																														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																							
										IMMEDIATE CAUSE (a)										Cerebral Hemorrhage																																																											
										DUE TO, OR AS A CONSEQUENCE OF																																																																					
										(b)																																																																					
										DUE TO, OR AS A CONSEQUENCE OF																																																																					
										(c)																																																																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																																																															
219a. DATE OF OPERATION										219b. CONDITION FOR WHICH OPERATION WAS PERFORMED										220a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										220b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																																																	
221a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> (If either, notify medical examiner)										221b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										221c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)																																																											
221d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>										221e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC										221f. LOCATION Street or R.F.D. No. City or Town County State																																																											
222a. I certify that (1) (this hospital) attended the deceased from Sept. 23, 1968, to Oct. 9, 1968, that (2) (we) lost the deceased alive on Oct. 9, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.																																																																															
22b. SIGNATURE										22c. DATE SIGNED																																																																					
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																																																																					
Ohannes Sahakyan, M. D.										Prince George's Gen'l Hospital, Cheverly,																																																																					
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County)																																																	
Burial										10/12/68										Oakwood										Cheverly Va										Maryland																																							
24. FUNERAL DIRECTOR										ADDRESS										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																																																	
F. Gasch's Sons										Hyattsville, Maryland										DATE OCT 14 1968										Charles Judge																																																	



TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

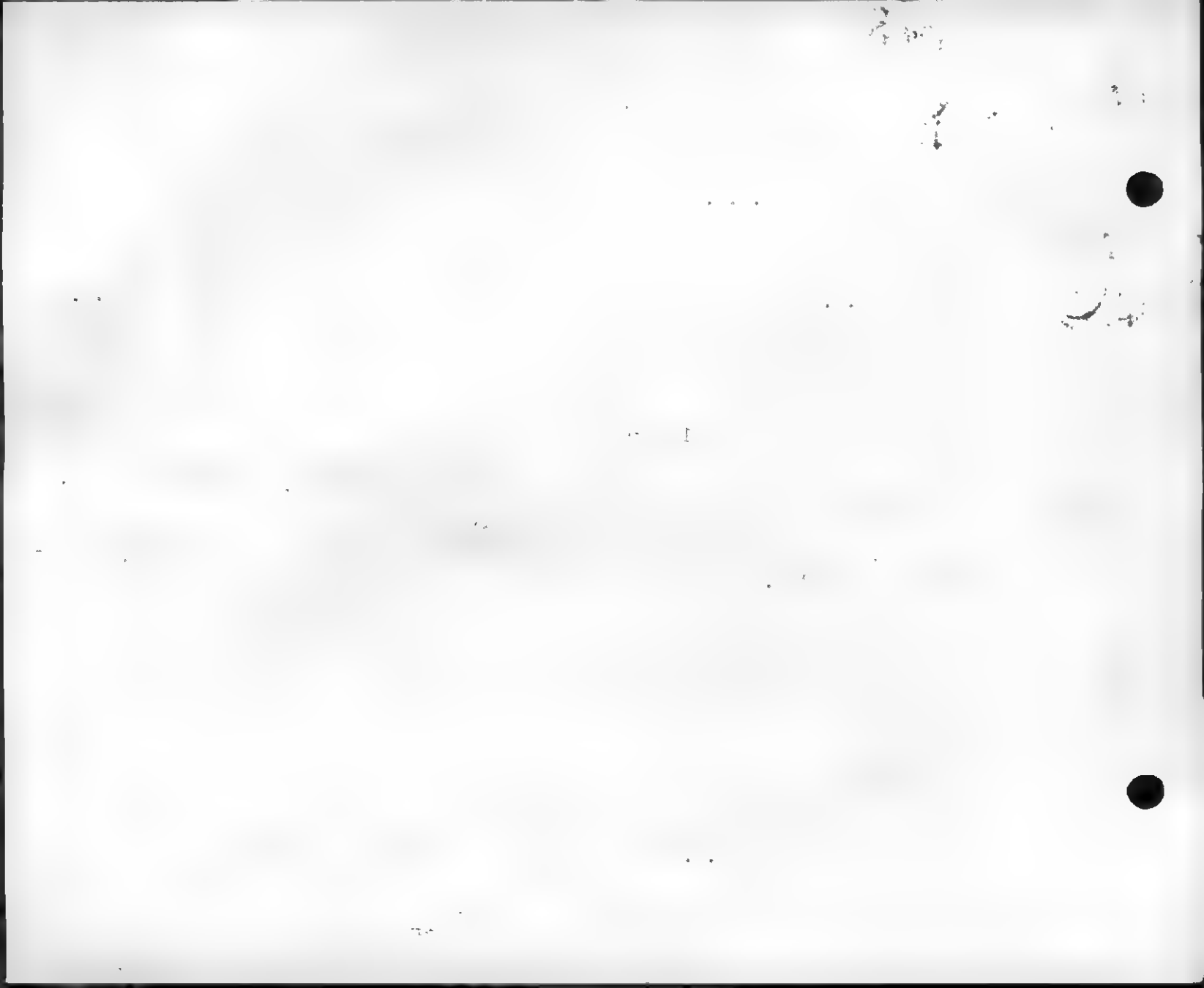
VR A15  
304A REV 1-68

14915

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

14925

1. DECEASED-NAME (Type or print) <b>Maude C. Moore</b>			2a. DATE OF DEATH Month <b>October</b> Day <b>13</b> Year <b>1968</b>			2b. HOUR <b>8:25</b> A.M.					
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>June 28, 1891</b>		6. AGE (In years last birthday) <b>77</b> YRS		IF UNDER 1 YEAR MONTHS <b>1</b> DAYS <b>13</b>		IF UNDER 24 HRS. HOURS <b>8</b> MIN. <b>25</b>	
7a. BIRTHPLACE (State or foreign country) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince Georges</b> Md					
10. CITY OR TOWN OF DEATH <b>Glenn Dale</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Glenn Dale Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Unknown - Retired</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>D.C.</b>				13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Washington</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>2905 Nelson Place S.E.</b>	
14. FATHER'S NAME First <b>William</b> Middle <b>Couch</b> Last <b>Couch</b>			15. MOTHER'S MAIDEN NAME First <b>Elizabeth</b> Middle <b>Bruffy</b> Last <b>Bruffy</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b>			16b. SOCIAL SECURITY NO. <b>577-10-5449</b>			17. INFORMANT <b>Decedent</b> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bilateral bronchopneumonia</b> <b>not</b> DUE TO, OR AS A CONSEQUENCE OF <b>hemiparesis &amp; speech abnormality</b> 3 yrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>left cerebrovascular accident with rt./</b> DUE TO, OR AS A CONSEQUENCE OF <b>generalized arteriosclerosis</b> years APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Mechanical intestinal obstruction, improved; fracture of right femur, 2/68, treated by traction, healed.</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>11</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from <b>8/3/</b> 19 <b>66</b> , to <b>10/13/</b> 19 <b>68</b> , that (X) (we) last saw the deceased alive on <b>10/13/</b> 19 <b>68</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) <b>not</b> view the body after death.											
22b. SIGNATURE <b>Moe Weiss</b>			DEGREE			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>10/13/1968</b>		
22d. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M.D.</b>			22e. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Maryland</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>Oct. 16, 1968</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor P.D. Md.</b>		
24. FUNERAL DIRECTOR <b>Veronica Lee Hone</b>			ADDRESS <b>4000 14th St. N.W.</b>			RECORDED BY REGISTRAR <b>Wash. D.C. 20002</b>			25. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		
DATE <b>OCT 15 1968</b>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers on pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV

<div style="display: flex; justify-content: space-between;"> <span>14910</span> <span>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>14926</span> </div> <div style="text-align: center;">             Item 5 Film 405  <b>CERTIFICATE OF DEATH</b> </div>																
1. DECEASED-NAME (Type or print)			First <b>Dela</b>			Middle <b>Moreland</b>			Last			2a. DATE OF DEATH Month <b>Oct</b> Day <b>5</b> Year <b>68</b>			2b. HOUR <b>7:40PM</b>	
3. SEX <b>Female</b>			4. RACE <b>Cauc.</b>			5. DATE OF BIRTH <b>12-19-1892</b>			6. AGE (In years last birthday) <b>76</b> YRS.			7. UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		8. UNDER 24 HRS HOURS <b>0</b> MIN <b>0</b>		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Prince Georges</b> Md.							
10. CITY OR TOWN OF DEATH <b>Cheverly</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Georges Gen. Hosp.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY							
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Prince Georges</b>			13c. CITY OR TOWN <b>Capitol Hgts</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>513 61st Avenue</b>				
14. FATHER'S NAME First <b>Elsroed</b> Middle <b>?</b> Last <b>Elsroed</b>			15. MOTHER'S MAIDEN NAME First <b>Unknown</b> Middle <b></b> Last <b></b>													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>			16b. SOCIAL SECURITY NO.			17. INFORMANT <b>Ernest E. Moreland</b> Address <b>513-61st Ave. Capt. Hgts. Md.</b>										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pulmonary Edema</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Massive Pneumonia Right Lung</b>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4</b>																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State										
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept. 7, 1968</b> to <b>Oct. 5, 1968</b> , that (I) (we) last saw the deceased alive on <b>Oct. 5, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <b>William Brainin</b>															22c. DATE SIGNED <b>10/5/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>WM BRAININ</b>			22e. ADDRESS <b>6056 Central Ave. Capitol Hgts Md</b>													
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>10-9-68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Suitland Pr. Geo. Md.</b>							
24. FUNERAL DIRECTOR <b>Wilhelm Funeral Home</b>			ADDRESS <b>4308 Suitland Rd.</b>			25a. REC'D BY REGISTRAR <b>OCT 11 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							

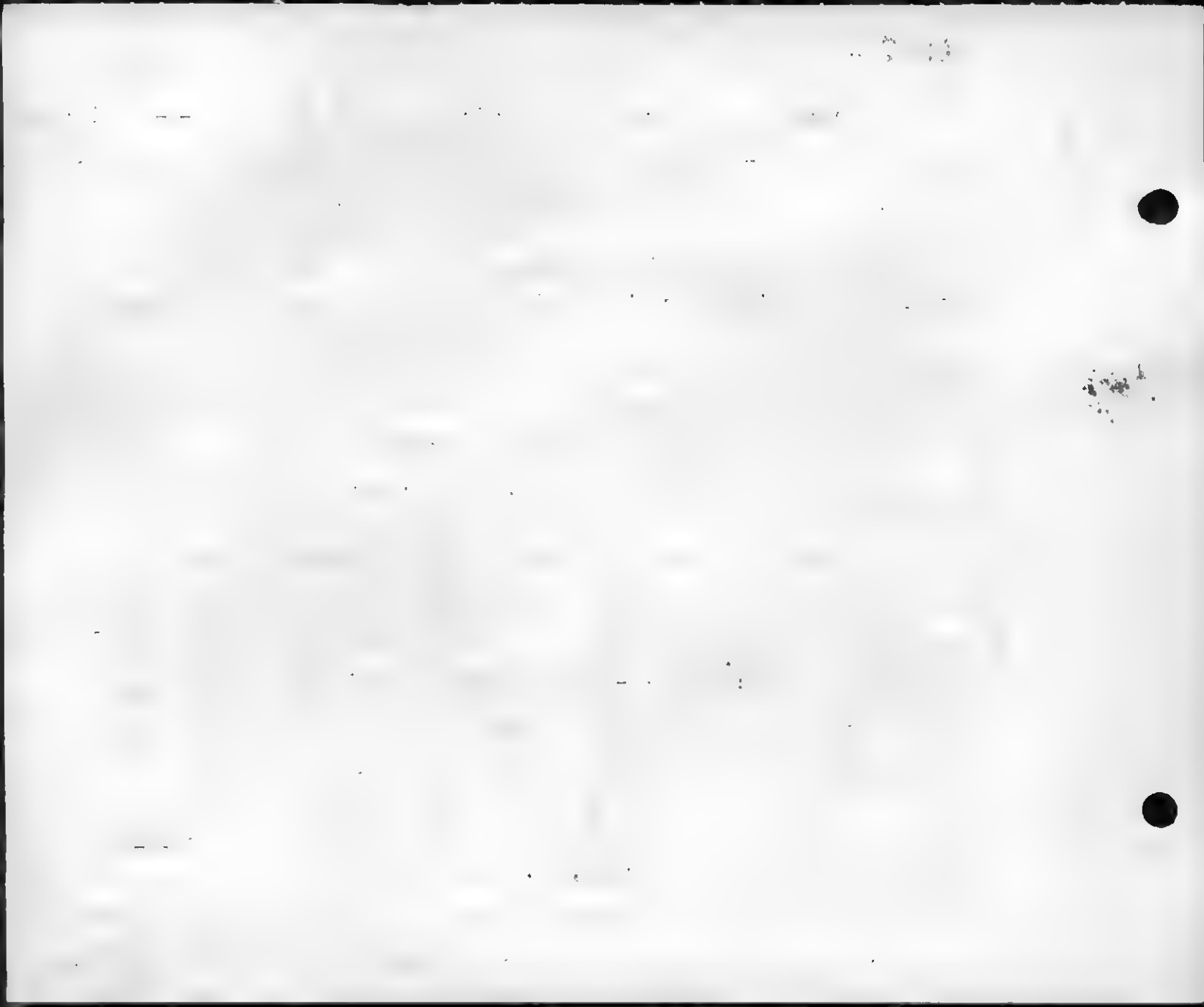
1071

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <span>14917</span> <span>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>14927</span> </div> <div style="text-align: center;"> <b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b> </div>											
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
Suzanne Lea Morris						Month Day Year			10-3-68 1910:00am		
3 SEX	4. RACE	5. DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Female	White	10-22-1939	28 YRS					Month Day Year		10 3 68 1912:45pm	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.		
Vermont		U S A				Prince George's					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Bowie			4014 Croydon Lane			housewife			home		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before death)			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Maryland			Prince George's		Bowie		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4014 Croydon Lane		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			ADDRESS					
Charles Coleman			Grace Dersoia			Lawrence W Morris Bowie, Md.					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			
no					Lawrence W Morris Bowie, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple stab wounds of chest										Minutes	
DUE TO, OR AS A CONSEQUENCE OF											
(b) And multiple lacerations of neck										Minutes	
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
CAUSE OF DEATH			10:00am 10-3-19 68			Attacked by assailant					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State					
			home			Same as #13					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED		
John Kehoe MD			John Kehoe MD			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			10-4-68		
			Riverdale, Md.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			Oct 6, 1968		Scottsville Cemetery			Danby Vermont			
24. FUNERAL DIRECTOR						25a. REC'D BY REG. STRAR		25b. REGISTRAR'S SIGNATURE			
F. Gasch's Sons Hyattsville, Md.						DATE OCT 8 1968		f Charles Judge			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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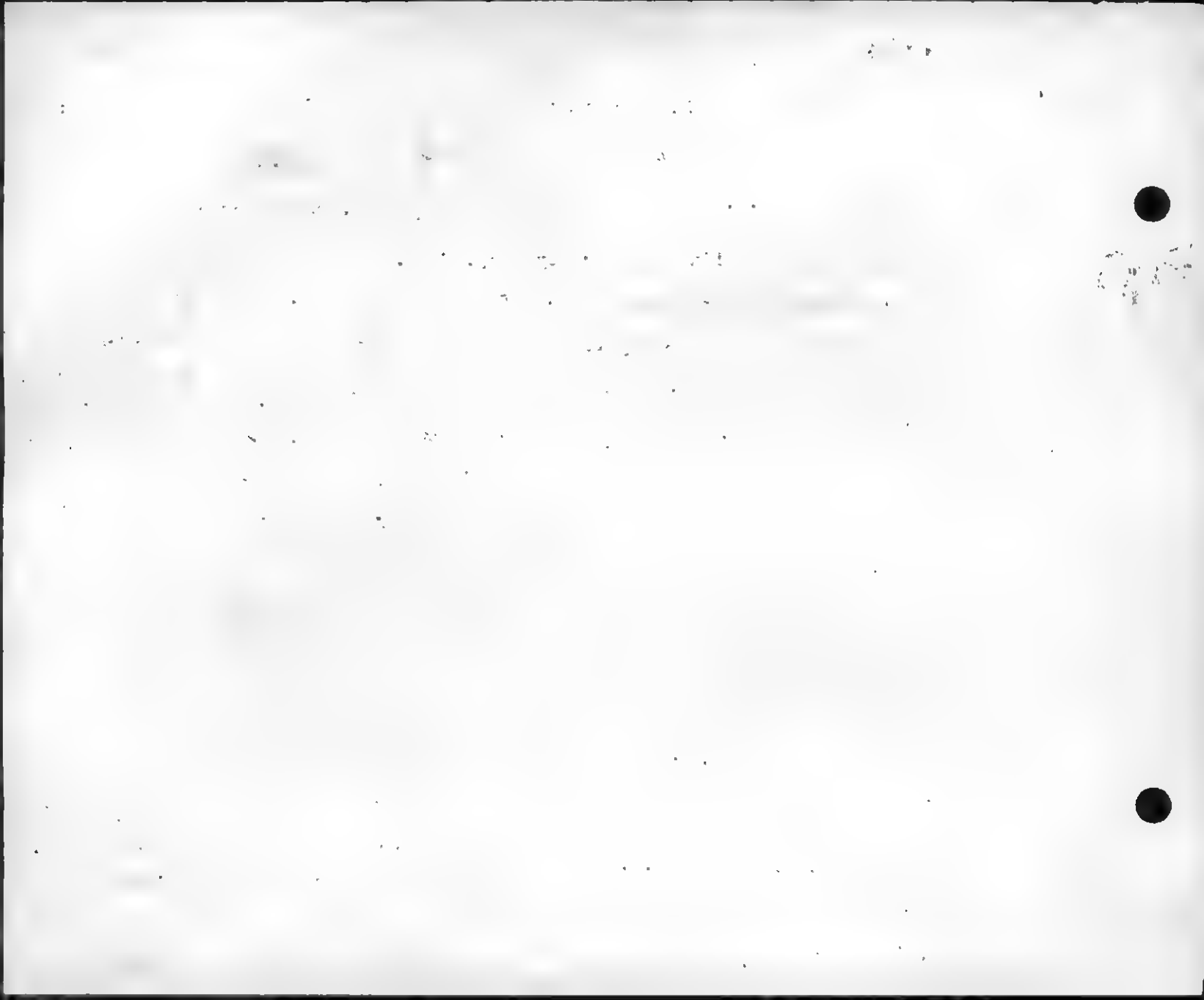
VR A15  
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

14913

14928

1. DECEASED-NAME (Type or print)		First Mary		Middle M.		Last Murphy		2a. DATE OF DEATH 10 Month 6 Day 68 Year				2b. HOUR 6:15 P	
3 SEX Female		4 RACE white		5. DATE OF BIRTH 3/18/94				6 AGE (In years last birthday) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md.							
10 CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Clinton Community Hosp., Corp.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Baseball Player				12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution on: Residence before admission) STATE Maryland		13b. COUNTY Charles		13c. CITY OR TOWN Waldorf		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Rt. 3 Box 438					
14 FATHER'S NAME First Daniel		Middle Bridgett		Last Murphy		15 MOTHER'S MAIDEN NAME First Mary		Middle Julia		Last Murphy			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. 217-42-4554		17 INFORMANT Address 6439 Livingston Mary Lillian Buckler/Rd. Oxon Hill, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GENERAL VISCERAL FAILURE DUE TO, OR AS A CONSEQUENCE OF GEN. ARTERIO-SCLEROSIS (b) DUE TO, OR AS A CONSEQUENCE OF DIABETES MELLITUS (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) K-S-W with UREMIA.													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from 9/5, 19 68, to 10/6, 19 68, that (I) (we) last saw the deceased alive on 10/6/68, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Robert W. Merkle		22c. DATE SIGNED 10-6-68		22d. PHYSICIAN'S NAME (Type) Robert W. Merkle, M.D.									
22e. ADDRESS Clinton Community Hospital Corp. 7945 Woodyard Rd., Clinton, Maryland													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10-9-68		23c. NAME OF CEMETERY OR CREMATORY St. Peter's Cem.				23d. LOCATION (City or Town) (County) (State) WALDORF, CHARLES, MD.					
24. FUNERAL DIRECTOR Funeral Home, Waldorf, Md.		25a. REC'D BY REGISTRAR DATE OCT 14 1968		25b. REGISTRAR'S SIGNATURE James J. Jones									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) and any event, within 72 hours after death should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1

14919

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

14929

1. DECEASED-NAME (Type or print) <b>MARVIN THOMAS NEAL, SR.</b>			2a. DATE OF DEATH <b>October 18</b> Day <b>1968</b> Year		2b. HOUR PM <b>8:25</b>
3. SEX <b>MALE</b>	4. RACE <b>CAU</b>	5. DATE OF BIRTH <b>Jan 7, 1912</b>		6. AGE (In years last birthday) <b>56</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>KENTUCKY</b>	7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>PRINCE GEORGE'S</b> Md.		
10. CITY OR TOWN OF DEATH <b>ADFB</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Malcom Grow USAF HOSP.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>USAF-ADMINISTRATION</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>MILITARY</b>	
13a. U.S.A. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>	13b. COUNTY <b>PRINCE GEORGES</b>	13c. CITY OR TOWN <b>FORESTVILLE</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>8205 BELTZ DRIVE</b>	
14. FATHER'S NAME First Middle Last <b>THOMAS - NEAL</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>PUGH</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>1938-1961 291-03-6606</b>		17. INFORMANT Address <b>POPPY P. NEAL 8205 BELTZ DR. FORRESTVILLE, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE CORONARY THROMBOSIS</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>SEVERE CORONARY ARTERIOSCLEROSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>REMOTE MYOCARDIAL INFARCTION</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>18 Oct</b> , 19 <b>68</b> , to <b>18 Oct</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>18 Oct</b> , 19 <b>68</b> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>John Goldman, M.D.</b>		DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>19 Oct 68</b>	
22d. PHYSICIAN'S NAME (Type) <b>JOHN GOLDMAN, M.D.</b>		22e. ADDRESS <b>USAF HOSP. ANDREWS, PRINCE GEORGES, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>10-23-68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem.</b>		23d. LOCATED ON (City or Town) (County) (State) <b>Arlington Virginia</b>	
24. FUNERAL DIRECTOR <b>W.W. Chambers</b>		ADDRESS <b>517-112 S.E.</b>		25a. REC'D BY REGISTRAR <b>OCT 30 1968</b>	
				25b. REGISTRAR'S SIGNATURE <b>John W. Chambers</b>	

Phillie

Colington, Virginia

Colington Water Co.  
215 11<sup>th</sup> St.  
N.E.

10-2-28

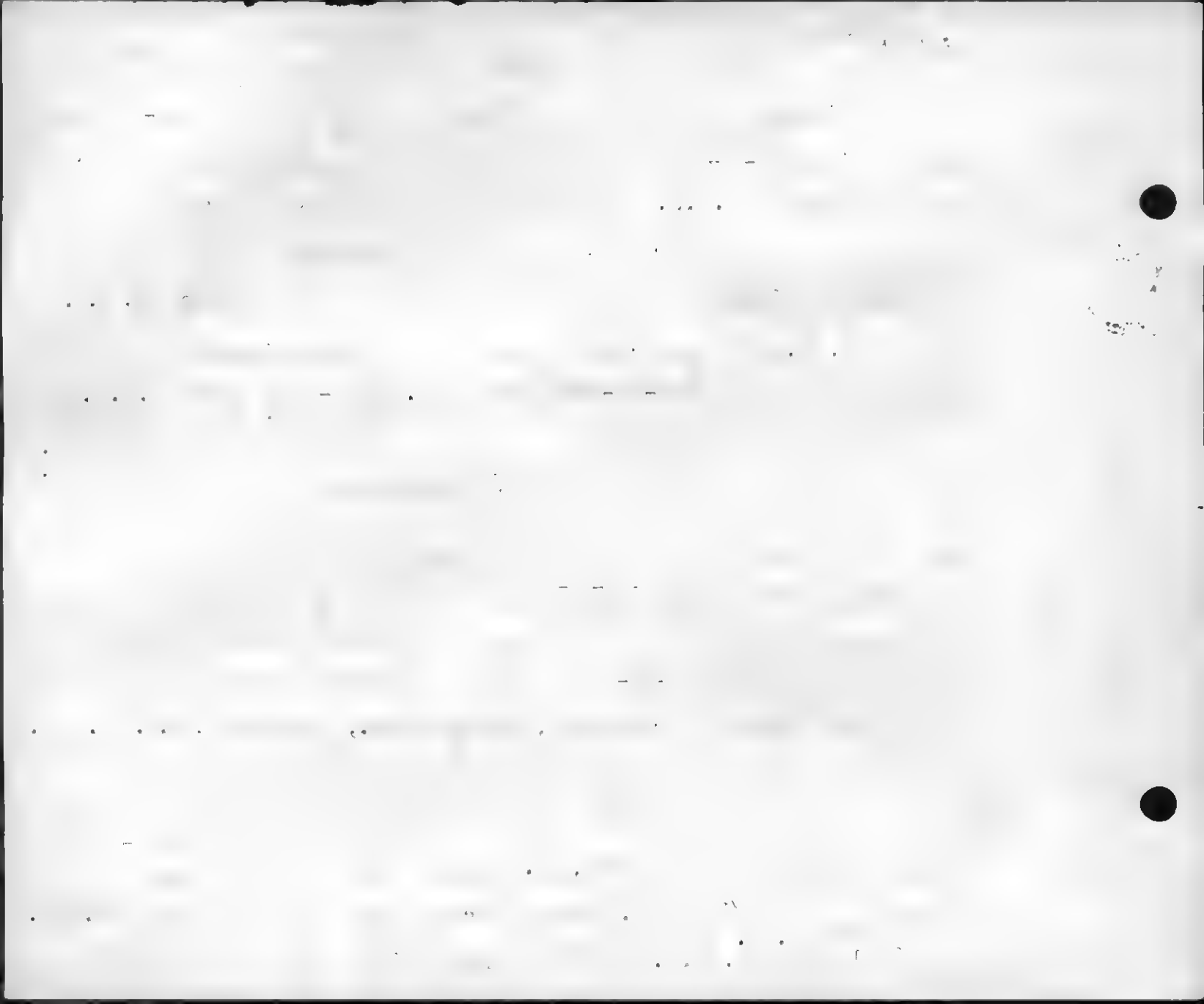
Phillie

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
14920		MEDICAL EXAMINER'S CERTIFICATE OF DEATH						14930					
1 DECEASED NAME (Type or Print)			First		Middle		Last		2a. DATE KNOWN OF DEATH		2b. HOUR		
Minnie			Newton						Month Day Year		10-16-68 192:15pm		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD	
Female		White		10-25-1878		89 YRS						Month Day Year	
10		16		68		19		2:30pm					
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH			12b. KIND OF BUSINESS OR INDUSTRY	
Pennsylvania			U.S.A.						Prince George's			Md	
1d. CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)					
Hyattsville				Hyattsville Nursing home				Homemaker					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				13b. CITY OR TOWN				13c. INSIDE CITY, TOWN, OR VILLAGE		13e. STREET AND NUMBER			
District of Columbia				Washington				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5521 Colorado Ave. N.W.			
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME			First Middle Last	
W. C.			Gardner						Unobtainable				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT						ADDRESS	
no			578-60-9266			Marion L. Boat-7520 17th St. N.W.						Washington, DC	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Malnutrition										over 1 mo.			
DUE TO, OR AS A CONSEQUENCE OF Anorexia										over 1 mo.			
(b) From Generalized arteriosclerosis													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
4500 Fracture of right hip - 8-26-68													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?				
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
CAUSE OF DEATH			PM P.M. 8-26-1968			Fell at Hyattsville Nursing Home							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION: Street or R.F.D. No. City or Town County State							
Hyattsville Nursing Home			6500 Riggs Rd., Hyattsville, P.G. Co., Md.										
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>						22b. DATE SIGNED				
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						10-17-68				
John Kehoe MD			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						ADDRESS (Street, city, town, or county)				
Riverdale, Md.													
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)				
Cremation			10/18/68		Ft. Lincoln Crematory				Prince Georges Co. Md.				
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
The S. H. Hines Company						2901 14th St. N.W. Washington, DC		OCT 21 1968					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, pay the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14921

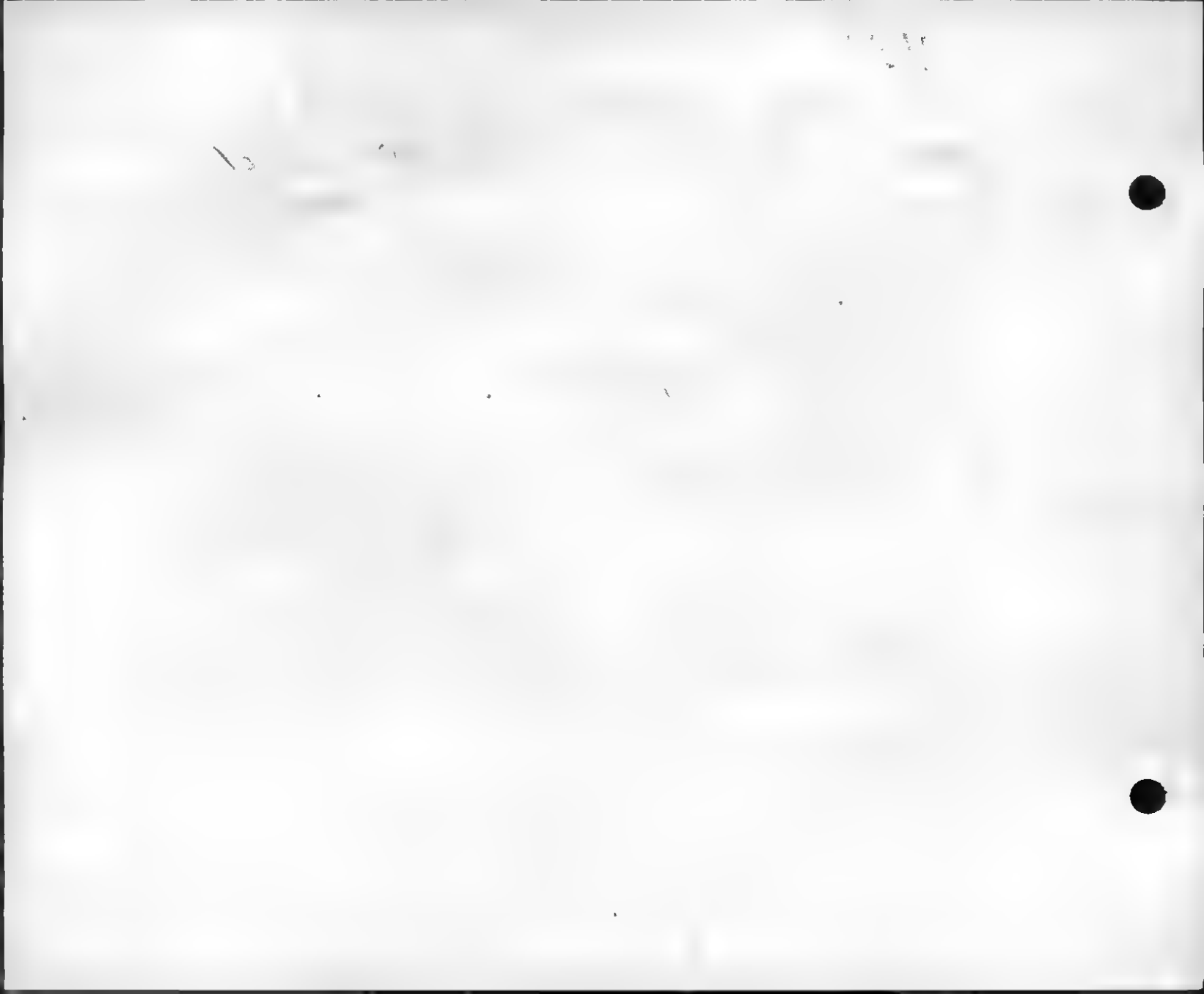
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14931

1. DECEASED-NAME (Type or print) <b>ERMA SIZER NOTTINGHAM</b>			2a. DATE OF DEATH <b>10</b> Month <b>16</b> Day <b>68</b> Year			2b. HOUR <b>3:38</b> PM					
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>5-23-1907</b>		6. AGE (In years lost birthday) <b>61</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince Georges</b> Md.					
10. CITY OR TOWN OF DEATH <b>Clinton, Md.</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>PINE VIEW GARDEN</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>house wife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Md.</b>				13b. COUNTY <b>Charles</b>		13c. CITY OR TOWN <b>La Plata</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First Middle Last <b>Edward Sizer</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Mattie Jackson</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO <b>578-12-7060</b>		INFORMANT <b>9600 Avenue Rd. Silver</b> <b>Mr. Benjamin J. Nottingham-Son Spring</b> Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Circulatory Collapse</b> <b>4369</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Pneumonia, bronchial</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>C.V.A. &amp; Pulmonary Emboli</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>3312</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b> P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>9</b> - <b>10/16/</b> , 19 <b>68</b> , to <b>10/16/</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>10/16/</b> , 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE <b>Alfred R Lapin</b>						22c. DATE SIGNED <b>10/16/1968</b>					
22d. PHYSICIAN'S NAME (Type) <b>ALFRED R LAPIN</b>						22e. ADDRESS <b>Clinton, Maryland</b>					
23a. BURIAL, CREMATION <b>Burial</b>			23b. DATE <b>10/19/1968</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Bladensburg, Maryland</b>		
24. FUNERAL DIRECTOR <b>Archast Funeral Home, Inc. Md.</b>						25. RECEIVED BY REGISTRAR <b>06/23/68</b>			25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <span>14922</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>14932</span> </div>											
1. DECEASED-NAME (Type or print) <b>John E. Owens</b>				2a. DATE OF DEATH Month <b>Oct.</b> , Day <b>2</b> , Year <b>1968</b>				2b. HOUR <b>3 P. M.</b>			
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>March 29, 1886</b>				6. AGE (In years last birthday) <b>82</b> YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George's Md.</b>					
10. CITY OR TOWN OF DEATH <b>Cheverly</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo. Gen'l Hospital</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Stationer</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>				13b. COUNTY <b>Prince George's</b>		13c. CITY OR TOWN <b>Oxon Hill</b>		3a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>5600 Livingston Rd.</b>	
14. FATHER'S NAME First Middle Last <b>John D. Owens</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Elizabeth McQuaden</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. <b>577-26-6591</b>		17. INFORMANT Address <b>Charles A. Owens, North Beach Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC AND RESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic cardiovascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>Malnutrition - Severe dehydration</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Malnutrition - Severe dehydration</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <del>he</del> (this hospital) attended the deceased from <b>Sept. 30, 1968</b> to <b>Oct. 2, 1968</b> , that <del>we</del> (we) lost saw the deceased alive on <b>Oct. 2, 1968</b> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>it</del> (we) (did) <del>not</del> view the body after death.											
22b. SIGNATURE <b>Luis F. Bentolilla</b>				DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>10-3-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Luis F. Bentolilla, M. D.</b>				22e. ADDRESS <b>Prince Geo. Gen'l Hospital, Cheverly, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE <b>10-5-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Washington National</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland P. H. Md.</b>			
24. FUNERAL DIRECTOR <b>W. W. Chambers</b>				ADDRESS <b>6. 517-11 St. S. E.</b>				25a. REC'D BY REGISTRAR <b>OCT 9 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MIDDLE											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) Salvatore			First Salvator			Middle M.			Last Petrone		
2a. DATE OF DEATH Oct.			Month 4			Day 1968			2b. HOUR 1:30A		
3 SEX Male			4. RACE Caucasian			5. DATE OF BIRTH 4/29/02			6. AGE (In years last birthday) 66 YRS		
7a. BIRTHPLACE (State or foreign country) Wash. D.C.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Prince George's Md.		
10. CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo.Gen'l Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Ret. U.S. Post Office			12b. KIND OF BUSINESS OR INDUSTRY -		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b. COUNTY Prince George's			13c. CITY OR TOWN Riverdale			13d. INSIDE CITY LIM TSY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER 60700 3rd St.			14. FATHER'S NAME First Claude			Middle Petrone			15. MOTHER'S MAIDEN NAME First Ella		
Middle Storty			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes			16b. SOCIAL SECURITY NO 1-27-39 577-58-7333			17. INFORMANT Mrs. Lucy W. Petrone (above address) (Wife)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GENERALIZED CARCINOMATOSIS										2 MONTHS	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA OF RT CHOANAL										1 YEAR.	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1992											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from SEP 1, 1967, to Oct. 4, 1968, that (I) last saw the deceased alive on Oct. 4, 1968, and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.											
22b. SIGNATURE Samuel J. N. Sugar MD						22c. DATE SIGNED Oct. 4, 1968					
22d. PHYSICIAN'S NAME (Type) Samuel J. N. Sugar, M.D.						22e. ADDRESS 4637 Eastern Ave., Washington, D.C. 20018					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 10/7/68			23c. NAME OF CEMETERY OR CREMATORY Stonewall Mem. Gard. Cem.			23d. LOCATION (City or Town) (County) (State) Manassas, Va.		
24. FUNERAL DIRECTOR Valley's Funeral Home Inc.						25a. REC'D BY REGISTRAR DATE OCT 11 1968			25b. REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

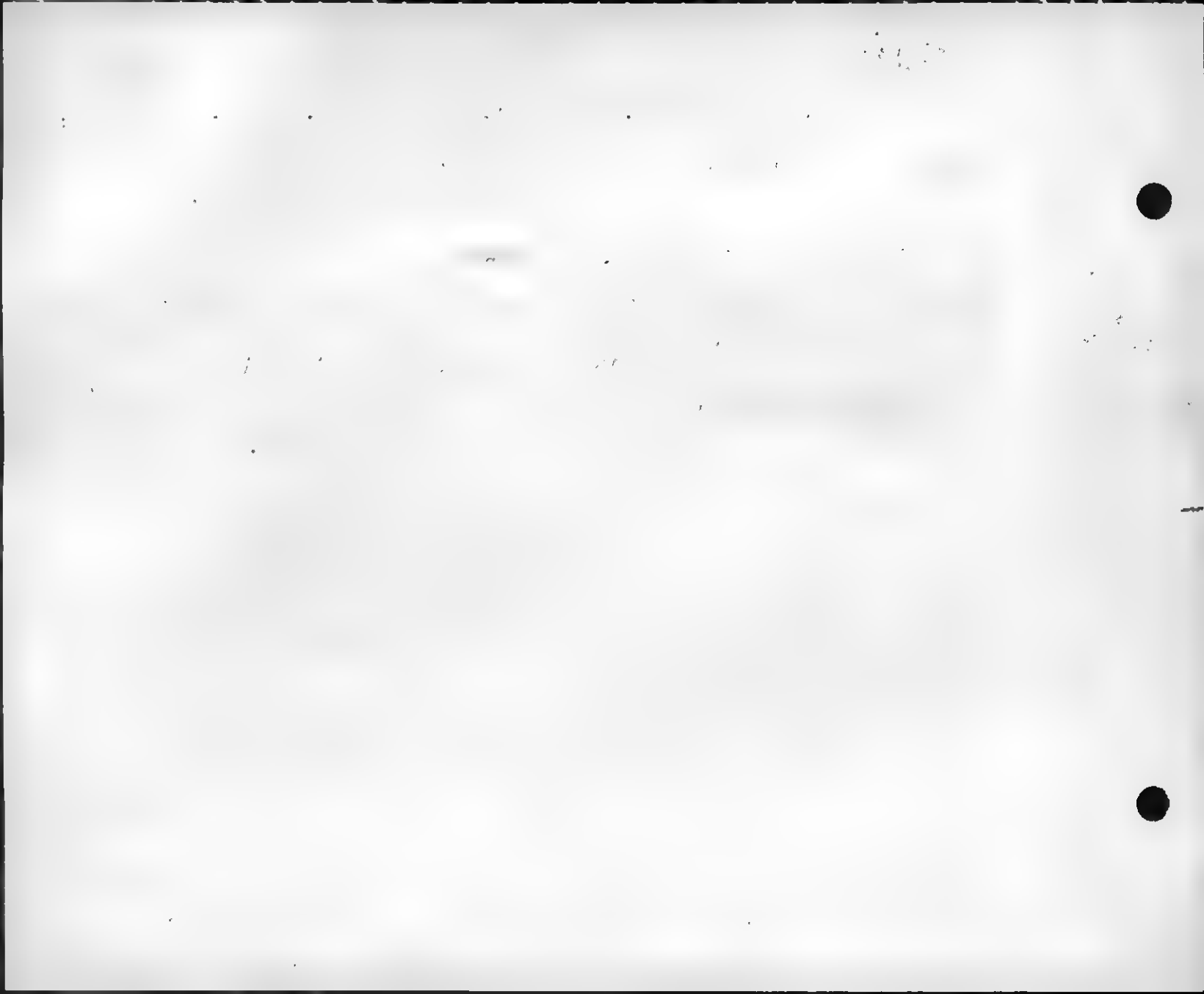
Item 1 Film 406 11/8/68  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14924

CERTIFICATE OF DEATH

14934

1. DECEASED-NAME (Type or print) <b>Ethel</b>			First	Middle <b>M. Harper</b>	Last <b>Pettit</b>	2a. DATE OF DEATH <b>Oct. 28, 1968</b>			2b. HOUR <b>5:50A</b>			
3 SEX <b>Female</b>		4 RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>9/3/79</b>		6 AGE (In years last birthday) <b>89</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a BIRTHPLACE (State or foreign country) <b>Md</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Prince George's</b> Md						
10 CITY OR TOWN OF DEATH <b>Cheverly</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo. Gen'l Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>home</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Prince George's</b>		13c. CITY OR TOWN <b>Hyattsville</b>		3d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13e. STREET AND NUMBER <b>6500 Riggs Road</b>			
14 FATHER'S NAME <b>John Collinson Harper</b>			First	Middle	Last	15 MOTHER'S MAIDEN NAME <b>Rowena Hambleton Auld</b>			First Middle Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>no</b>			16b. SOCIAL SECURITY NO <b>220 44 8346</b>		17. INFORMANT <b>Nicholas Orem Jr</b>			Address <b>Hyattsville, Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma of the colon with metastasis.</b> <b>10-28</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>15-28</b>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC			21f. LOCATION Street or RFD No		City or Town		County State		
22a. I certify that (I) <del>(the deceased)</del> attended the deceased from <b>June</b> , 19 <b>56</b> , to <b>10/28</b> , 19 <b>68</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>10/28</b> , 19 <b>68</b> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> (did) (did not) view the body after death.												
22b. SIGNATURE <b>Norman D. Compak MD</b>						ATTENDING PHYS <input checked="" type="checkbox"/> MED <input type="checkbox"/> STAFF <input type="checkbox"/> DIRECTOR PHYS		22c. DATE SIGNED <b>10/28/68</b>				
22d. PHYSICIAN'S NAME (Type) <b>NORMAN D. COMPAK</b>						22e. ADDRESS <b>3503 PERAY ST MT RAINIER MD</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Entombment</b>			23b. DATE <b>Oct 30, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>					
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>						ADDRESS <b>Hyattsville Md</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 31 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



14925

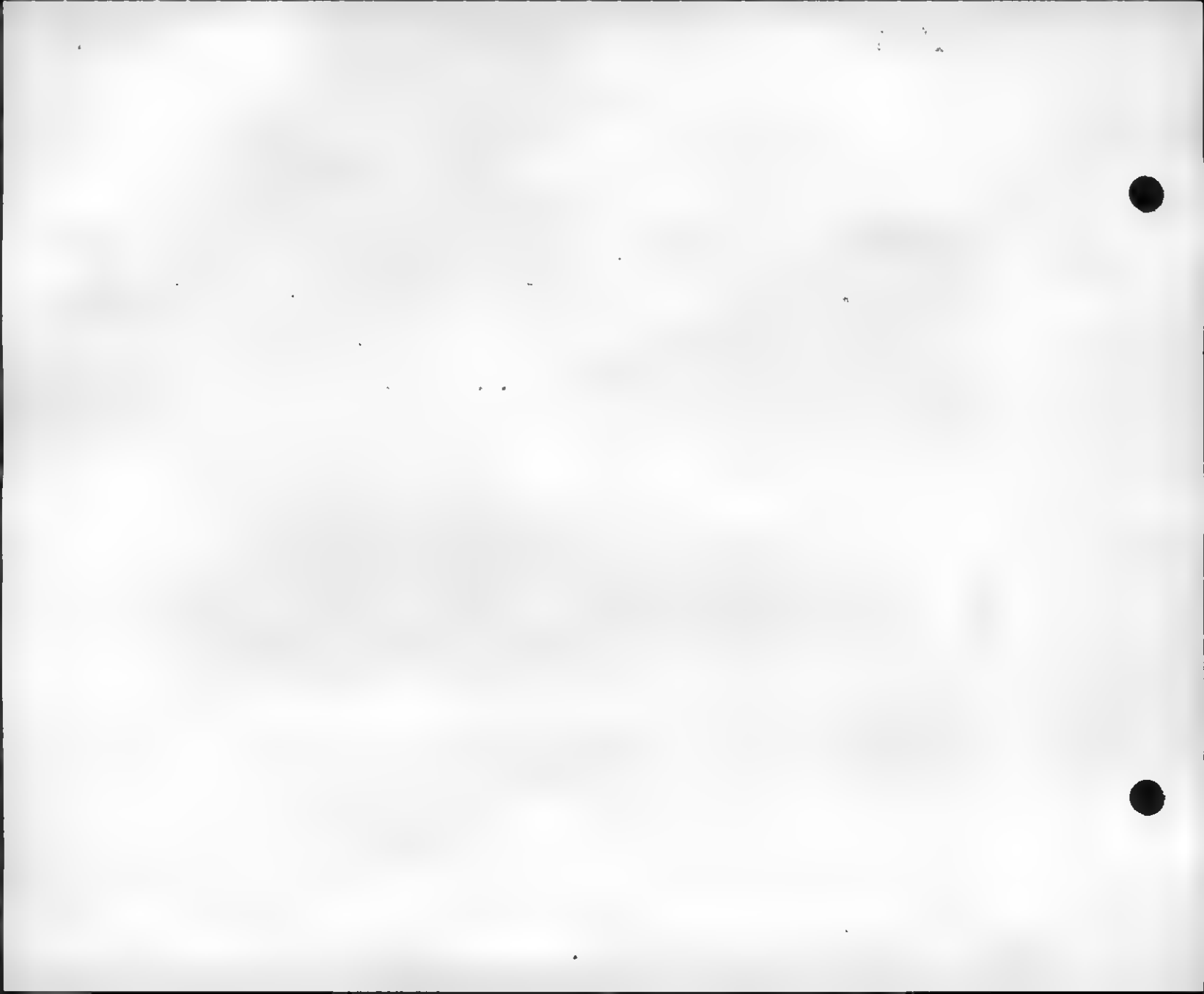
## CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>Kucy W. Pickersgill</i>			2a. DATE OF DEATH Month <i>10</i> Day <i>18</i> Year <i>68</i>			2b. HOUR <i>10 A</i> M	
3 SEX <i>FEMALE</i>		4. RACE <i>CAUCAS.</i>		5. DATE OF BIRTH <i>2-9-1882</i>		6. AGE (in years last birthday) <i>86</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>New Jersey</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Prince George's</i> Md.	
10. CITY OR TOWN OF DEATH <i>Forestville</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Regent Nursing Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>PG</i>		13c. CITY OR TOWN <i>Suitland</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <i>5219 Meadowview Drive</i>							
14. FATHER'S NAME First Middle Last <i>Stephen Wheeler</i>				15. MOTHER'S MAIDEN NAME First Middle Last <i>Annie Hodgson</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. <i>Unknown</i>		17. INFORMANT Address <i>C.E. Shives, Same as #13 (Daughter)</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>COMA</i> <i>150 X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, <i>150 X</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>METASTATIC CARCINOMA OF OESOPHAGUS</i> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>ARTEROSCLEROTIC HEART DISEASE WITH CONGESTIVE HEART FAILURE</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY) OFFICE BUILDING ETC.		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>7-15-68</i> , 19 <i>68</i> , to <i>10-18</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>10-16</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Oliver B. Bond</i>				22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type) <i>OLIVER B. BOND</i>	
22e. ADDRESS <i>6872 RIVERDALE ROAD DUNDON LANHAM MD 20801</i>							
23a. BURIAL CREMATION, ETC. (Specify) <i>BURIAL</i>		23b. DATE <i>10-22-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Laurel Grove Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Patterson, N.J.</i>	
24. FUNERAL DIRECTOR <i>Wilhelm Funeral Home</i> <i>4308 Suitland Rd. SE, Suitland, Md.</i>				25a. REC'D BY REGISTRAR DATE <i>OCT 23 1968</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14926

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items, #5&6, Film G405 10/18/68

CERTIFICATE OF DEATH

14936

1 DECEASED NAME (Type or print) <b>Florence</b>		First <b>E.</b> Middle <b>Plater</b> Last		2a. DATE OF DEATH Month <b>October</b> Day <b>12</b> Year <b>1968</b>		2b. HOUR <b>8:00 PM</b>	
3 SEX <b>Female</b>		4 RACE <b>Negro</b>		5. DATE OF BIRTH <b>5-10-1942</b>		6 AGE (n years last birthday) <b>26</b> YRS	
7a BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince Georges</b> Md	
10 CITY OR TOWN OF DEATH <b>Riverdale</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>E. Leland Memorial</b>		12a USUAL OCCUPATION (Kind of work done during most of work life, even if retired.) <b>Domestic</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a USUA. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Washington, D.C.</b>		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER <b>126 45th St., S.E.</b>		14. FATHER'S NAME First <b>Wesley</b> Middle <b>Parker</b> Last		15 MOTHER'S MAIDEN NAME First <b>Sara</b> Middle <b>Brown</b> Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>unknown</b> (If yes give war or dates of service)		16b SOCIAL SECURITY NO. <b>216-16-5230</b>		17. INFORMANT <b>Roland Plater</b> Address <b>Prince Frederick-Md.</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>CVA</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>331x</b> (b) <b>arteriosclerosis cerebral</b> DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Arteriosclerosis generalized</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>9-27-1968</b> , to <b>10-12-1968</b> , that (I) (we) last saw the deceased alive on <b>10-12-1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>D. R. Purdie, MD</b>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
22d PHYSICIAN'S NAME (Type)				22e ADDRESS			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>10-12-68</b>		23c NAME OF CEMETERY OR CREMATORY <b>Mt. Hope Ch. Cem</b>		23d LOCATION (City or Town) (County) (State) <b>Sunderland Cal. Md</b>	
24. FUNERAL DIRECTOR <b>Pinkney E. Sewell</b>				ADDRESS <b>Prince Fred, Md.</b>		25a REC'D BY REGISTRAR DATE <b>OCT 15 1968</b>	
				25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



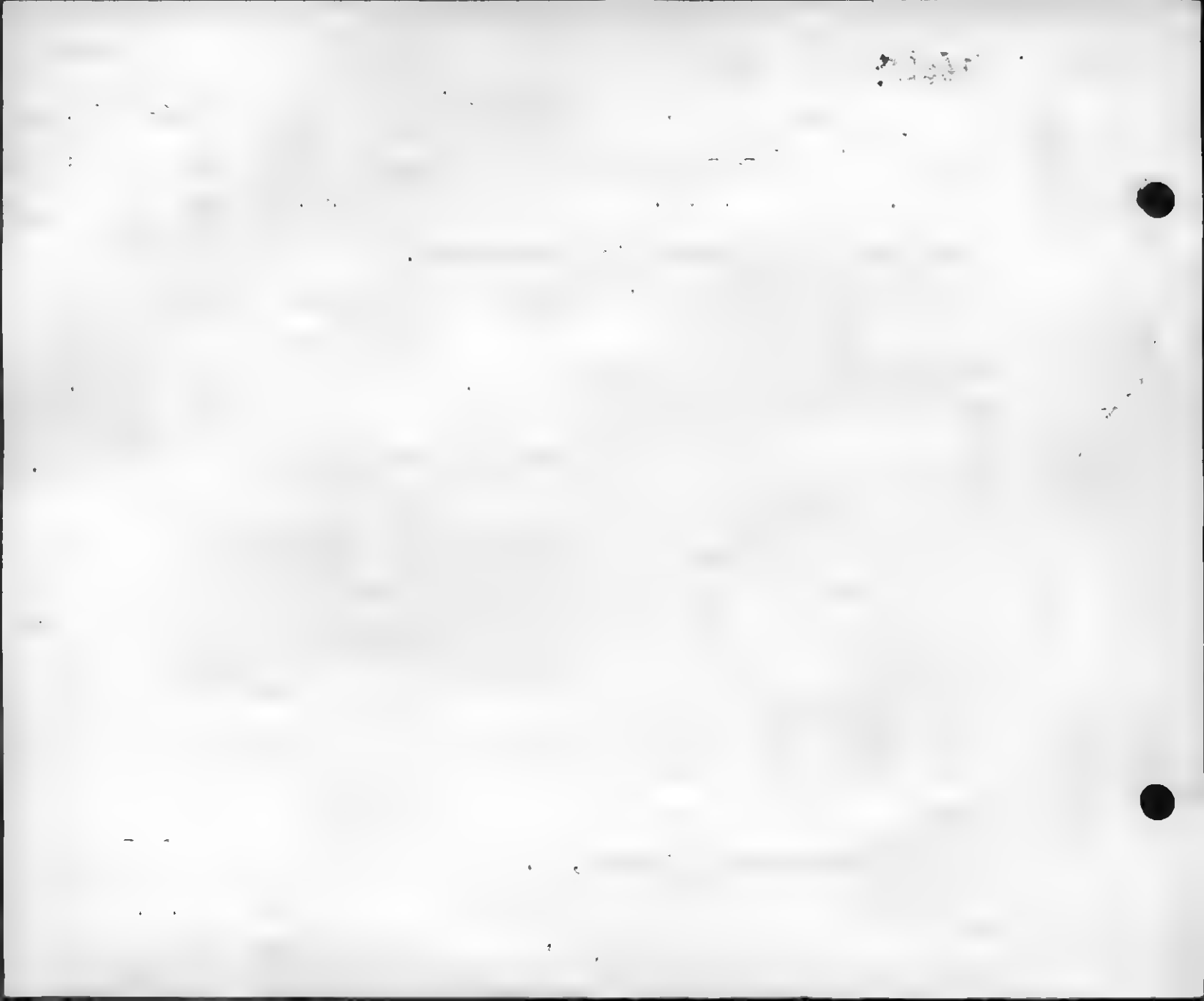
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil on item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

14937

1 DECEASED NAME (Type or Print) <b>Stanley P. Pogorzelski</b>		First Middle Last		2a DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 10-13-68 1911:00pm		2b H.O.J.R.	
3 SEX <b>Male</b>	4 RACE <b>White</b>	5. DATE OF BIRTH <b>11-18-1915</b>	6. AGE (in years) (as of birthday) <b>52 YRS</b>	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	2c DATE PRONOUNCED DEAD Month Day Year <b>10 14 68 .9 12:15am</b>	2d HOUR	
7a. BIRTHPLACE (State or foreign country) <b>Pa.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George's Md</b>	
10. CITY OR TOWN OF DEATH <b>Suitland</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hosp. to give street address) <b>Suitland Andrews Air Force Base Hosp.</b>		12a. USJAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Transportation</b>		2b. KIND OF BUSINESS OR INDUSTRY <b>Employee</b>	
13a. USJAL RESIDENCE (Where deceased lived, if not tuition: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Prince George's Suitland</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>5419 Walls Lane</b>	
14. FATHER'S NAME First Middle Last <b>Peter Pogorzelski</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Pauline Kolankiewicz</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>1941-45 183-12-1114</b>		17. INFORMANT <b>Harriet</b> ADDRESS <b>Mrs. Harriett Henderson Hillcrest Md.</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO, OR AS A CONSEQUENCE OF <b>Arteriosclerotic heart disease</b> (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes over 3 yrs.</b>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>7</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A M P M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John Kehoe</b> M.D. EXAMINER'S NAME (Type) <b>John Kehoe MD Riverdale, Md.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>10-14-68</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>Oct. 17, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Josephs</b>		23d. LOCATION (City or Town) (County) (State) <b>Chews Landing N. J.</b>	
24. FUNERAL DIRECTOR <b>Robert E. Wilhelm</b> ADDRESS <b>4308 Suitland Rd. Suitland Md.</b>				25a. REC'D BY REGISTRAR <b>OCT 17 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and page 4 may event, within 24 hours after death.

14928

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14938

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <b>Beatrice Josephine Porter</b>			2a. DATE OF DEATH Month <b>October</b> Day <b>11</b> Year <b>1968</b>			2b. HOUR. <b>11:05</b>				
3 SEX <b>Female</b>		4 RACE <b>Caucasian</b>		5 DATE OF BIRTH <b>April 11, 1889</b>		6 AGE (In years last birthday) <b>79</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN <b></b>		
7a BIRTHPLACE (State or foreign country) <b>Massachusetts</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A..</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Prince George's</b> Md				
10. CITY OR TOWN OF DEATH <b>Adelphi, Md.</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) <b>Hillhaven Nursing Home</b>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>School Teacher</b>			12b KIND OF BUSINESS OR INDUSTRY <b>Public Sch.</b>	
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <b>Md.</b>			13b COUNTY <b>Montgomery</b>			13c CITY OR TOWN <b>Silver Spring</b>			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER <b>8420 Navahoe Drive</b>			14. FATHER'S NAME First Middle Last <b>Cyrus Hibbard</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Florence Spear</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>Yes, or unknown</b>			16b SOCIAL SECURITY NO. <b>214-60-6620</b>			17 INFORMANT <b>Nursing Home Records</b>			Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ANOTEMIA, UREMIA &amp; PNEUMONIA</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>1750</b> (b) <b>OBSTRUCTIVE UROPATHY &amp; CREMIA 6 WEEKS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CREMIA OF UROBY &amp; METASTASES 6 YRS</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>PROTEINOSIS &amp; GENERALIZED</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3-4 weeks</b>		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or RFD No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <b>JULY 3, 1968</b> , to <b>OCT 11, 1968</b> , that (I) (we) last saw the deceased alive on <b>9/30, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death										
22b. SIGNATURE <b>Harold Sterling, MD</b>			DEGREE <b>MD</b>			ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>10/11/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>HAROLD STERLING, MD</b>			22e. ADDRESS <b>1352 UNIV BLVD E</b>							
23a. BURIAL (CREMATION, REMOVAL, etc.) <b>Cremation</b>			23b. DATE <b>Oct. 12, 1968</b>			23c. NAME OF CEMETERY OR CREMATORY <b>3rd Lincoln Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Calmar Manor Md</b>	
24. FUNERAL DIRECTOR <b>Arthur Walters</b>			ADDRESS <b>254 Carroll St. N.W. Washington, D.C. 20012</b>			25a. RECD BY REGISTRAR <b>DATE OCT 14 1968</b>			25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

MEDICAL CERTIFICATION

2001



2001



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

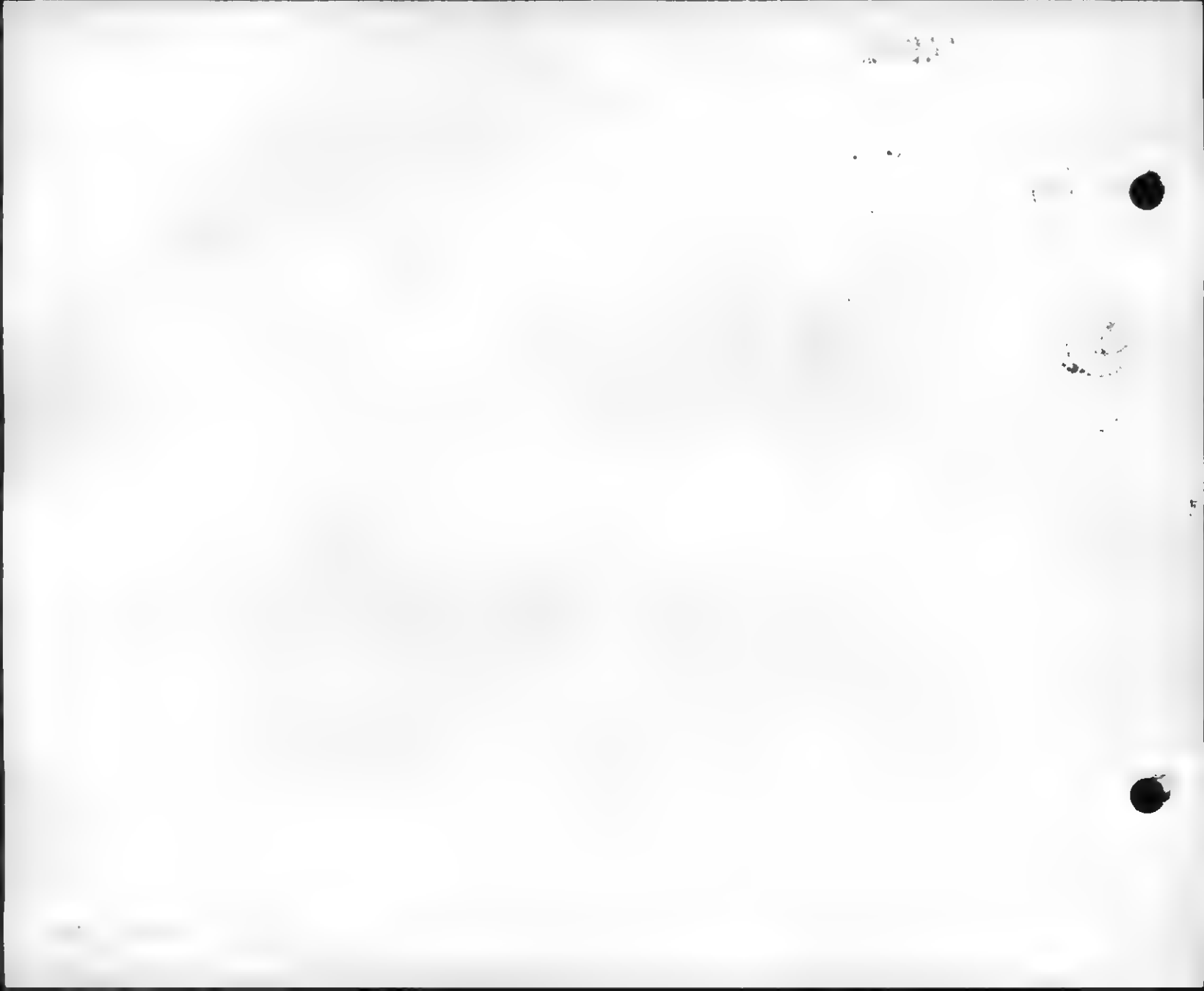
16

14928

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

14939

1. DECEASED-NAME (Type or print) <b>MARGERY Louise POWDERLY</b>			2a. DATE OF DEATH Month <b>OCT</b> Day <b>10</b> Year <b>68</b>			2b. HOUR- <b>9:35</b> M.	
3 SEX <b>F</b>		4. RACE <b>W</b>		5 DATE OF BIRTH <b>10-19-1886</b>		6 AGE (In years last birthday) <b>81</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George</b> Md.	
10. CITY OR TOWN OF DEATH <b>Hyattsville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>CARROLL MANOR</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>REGISTERED NURSE (RETIRED)</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>md.</b> COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>10102 Georgia Ave.</b>	
14. FATHER'S NAME First <b>JOSEPH</b> Middle <b>POWDERLY</b> Last <b>POWDERLY</b>				15. MOTHER'S MAIDEN NAME First <b>CATHERINE</b> Middle <b>LOFTUS</b> Last <b>LOFTUS</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>577 07 1815</b>		17 INFORMANT <b>CARROLL MANOR RECORDS</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Pulmonary infect</b> <b>4101</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b> <b>3 years</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>AUG 22</b> , 19 <b>65</b> , to <b>Oct 10</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>Oct 9</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Thomas F Collins MD</b> DEGREE <b>MD</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <b>Oct 10-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>THOMAS F COLLINS</b>				22e. ADDRESS <b>322-H OT NE.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>10-12-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT OLIVET CEMETERY</b>		23d. LOCAT ON (City or Town) (County) (State) <b>WASHINGTON D.C.</b>	
24 FUNERAL DIRECTOR <b>Francis Collins 4748-Wine Ave. N.W.</b>				25a. REC'D BY REGISTRAR DATE <b>OCT 14 1968</b> REGISTRAR SIGNATURE <b>John J. Judge</b>			





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

VR A15ME (5)  
10M REV 1-68

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14930

14940

1 DECEASED NAME (Type or Print) First Middle Last <b>Thomas LeRoy Proctor Jr.</b>			2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 10-17-68 193:20pm		2b HOUR
3 SEX <b>Male</b>	4 RACE <b>Negro</b>	5 DATE OF BIRTH <b>8-9-1968</b>	6 AGE (In years last birthday) YRS 2 8 MONTHS 0 DAYS HOURS 0 MIN.	2c DATE PROMULGATED DEAD Month 10 Day 17 Year 68 19 5:25pm	2d HOUR
7a BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9 COUNTY OF DEATH <b>Prince George's</b>		Md			
10 CITY OR TOWN OF DEATH <b>Cheverly</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince George Hospital</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>None</b>	
13a USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) - STATE <b>Maryland</b>		13b COUNTY <b>Prince George's</b>		13c CITY OR TOWN <b>Clinton</b>	
13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <b>8333 Old Alexander Ferry Rd.</b>			
14 FATHER'S NAME First Middle Last <b>Thomas L. Proctor</b>			15 MOTHER'S MAIDEN NAME First Middle Last <b>Mary G. Proctor</b>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16b SOCIAL SECURITY NO <b>None</b>		17 INFORMANT <b>Thomas L. Proctor</b>	
ADDRESS <b>8333 Old Alex Ferry Clinton, Md., Rd.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bilateral pneumonia, severe</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>4</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>John Kehoe MD</b>		M.D.		22b DATE SIGNED <b>10-18-68</b>	
EXAMINER'S NAME (Type) <b>John Kehoe MD Riverdale, Md.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE <b>10-21-68</b>		23c NAME OF CEMETERY OR CREMATORY <b>Resurrection Cem.</b>	
23d LOCATION (City or Town) (County) (State) <b>Clinton, Maryland</b>					
24 FUNERAL DIRECTOR <b>Rollins Funeral Home, Inc.</b>		25a REC'D BY REGISTRAR <b>OCT 22 1968</b>		25b REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

20827

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14932

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14941

1. DECEASED-NAME (Type or Print) First Middle Last Thomas HUEH Quinn			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 10-11-68 1912:30pm		2b. HOUR
3. SEX Male	4. RACE White	5. DATE OF BIRTH 10-2-1916	6. AGE (in years lost birthday) 52 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) BALT. MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
10. CITY OR TOWN OF DEATH Mt. Rainier		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 4108 33rd. Street		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) PLUMBER	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Prince George's		13c. CITY OR TOWN Mt. Rainier	
14. FATHER'S NAME First Middle Last THOMAS P. QUINN		15. MOTHER'S MAIDEN NAME First Middle Last ADELAIDE S. MOLLMAN		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES	
16b. SOCIAL SECURITY NO WW2 579-10-4081		17. INFORMANT ADDRESS 329 LAUREL AVE MARY QMALLONEE LAUREL MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 3rd degree burns 100% of body surface 890X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 12:30pm 10-11-68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Burned in house fire	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) home		21f. LOCATION Street or R.F.D. No City or Town County State same as #13	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) Riverdale, Md.		22b. DATE SIGNED 10-12-68	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10-15-68		23c. NAME OF CEMETERY OR CREMATORY Baltimore National	
24. FUNERAL DIRECTOR Donaldson Funeral Home Laurel Md		ADDRESS		23d. LOCATION (City or Town) (County) (State) Baltimore Md.	
25a. REC'D BY REGISTRAR OCT 18 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO-HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be expected within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

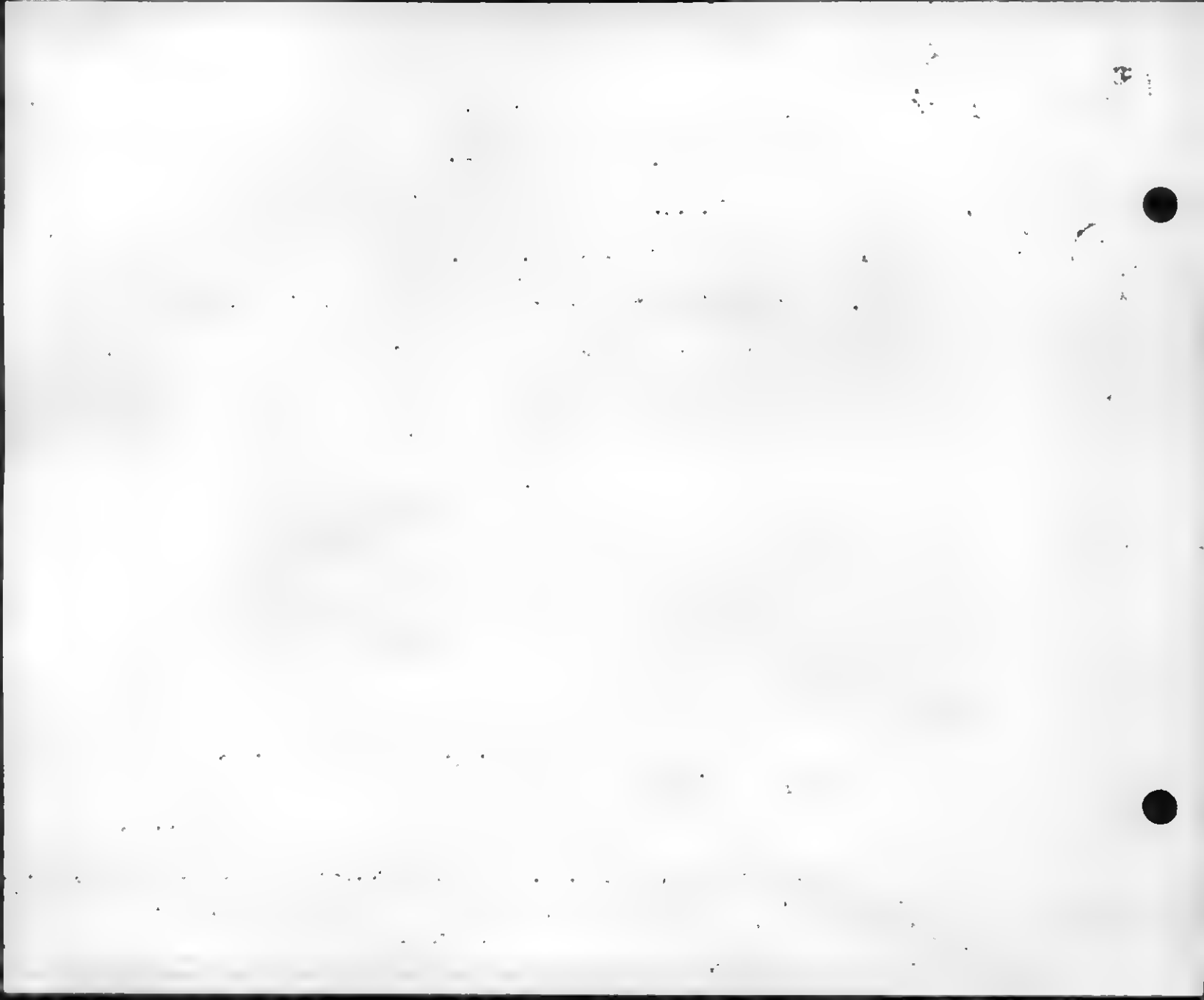
14932

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

14942

1. DECEASED NAME (Type or print) <b>Baby Boy</b>			First <b>Boy</b>			Middle <b></b>			Last <b>Rader</b>			2a. DATE OF DEATH Month <b>Oct</b> Day <b>5</b> Year <b>68</b>			2b. HOUR <b>5:45AM</b>								
3. SEX <b>Male</b>			4. RACE <b>Cauc.</b>			5. DATE OF BIRTH <b>10-05-68</b>			6. AGE (In years last birthday) <b>2</b> YRS			IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>			IF UNDER 24 HRS HOURS <b>2</b> MIN. <b></b>								
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Prince George's</b> Md.														
10. CITY OR TOWN OF DEATH <b>Cheverly</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Georges Gen. Hosp.</b>						12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Prince Georges</b>			13c. CITY OR TOWN <b>Seat Pleasant</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>7009 A Street</b>											
14. FATHER'S NAME <b>James Russell Rader</b>			First <b>James</b>			Middle <b>Russell</b>			Last <b>Rader</b>			15. MOTHER'S MAIDEN NAME <b>Sonja Kay Parker</b>			First <b>Sonja</b>			Middle <b>Kay</b>			Last <b>Parker</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT Address																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity</b> DUE TO, OR AS A CONSEQUENCE OF <b>Same</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>776</b>																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State																	
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct. 5, 1968</b> , to <b>Oct. 5, 1968</b> , that (I) (we) last saw the deceased alive on <b>Oct. 5, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE <b>Bernardo Alvarado, M. D.</b>			22c. DATE SIGNED <b>Oct. 7, 1968</b>			22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS <b>Prince Geo. Gen'l Hospital, Cheverly, Md.</b>														
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE <b>10/12/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Prince George's General</b>			23d. LOCATION (City or Town) (County) (State) <b>Cheverly, Maryland</b>														
24. FUNERAL DIRECTOR <b>Harvey W. Penn, Jr. Administrator</b>			25. ADDRESS <b>Hospital</b>			25a. DATED BY REGISTRAR <b>OCT 15 1968</b>			25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>														

MEDICAL CERTIFICATION



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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FOR STATE HEALTH DEPT.

Item 18 film 406 10-21-68 mt DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										14943											
Item#13c, FilmGLH0 MEDICAL EXAMINER'S CERTIFICATE OF DEATH																					
1. DECEASED NAME First Middle Last <b>14932 Francis Simon Redmond</b>						2a. DATE KNOWN OF DEATH Month Day Year <b>10-8-68 193:30am</b>			2b. HOUR												
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>11-2-1903</b>		6 AGE (In years last birthday) <b>64 YRS</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN <b>10 8 68 19 3:52am</b>		2c. DATE PRONOUNCED DEAD Month Day Year <b>10 8 68 19 3:52am</b>											
7a BIRTHPLACE (State or foreign country) <b>Md</b>			7b CITIZEN OF WHAT COUNTRY? <b>U S A</b>			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W-DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH <b>Prince George's Md</b>												
10 CITY OR TOWN OF DEATH <b>Cheverly</b>				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince George Hospital</b>				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Federal A A</b>			12b KIND OF BUSINESS OR INDUSTRY <b>U S Government</b>										
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>				13b COUNTY <b>Prince George's</b>		13c CITY OR TOWN <b>Glenn Dale</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <b>10013 Glenn Dale Rd., #T-2</b>											
14 FATHER'S NAME First Middle Last <b>Benjamin Redmond</b>						15 MOTHER'S MAIDEN NAME First Middle Last <b>Margaret Carmody</b>															
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16b SOCIAL SECURITY NO. (If yes give war or dates of service) <b>220 42 2041</b>		17 INFORMANT <b>Maxine C Redmond</b>				ADDRESS <b>Lanham, Md.</b>											
MEDICAL CERTIFICATION										18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO, OR AS A CONSEQUENCE OF <b>Arteriosclerotic heart disease</b> (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>over 14 yrs.</b>									
										PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4 1/2</b>											
										19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
										21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State															
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																					
ACTUAL SIGNATURE <b>John Kehoe MD</b>						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASS STANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED <b>10-9-68</b>												
EXAMINER'S NAME (Type) <b>John Kehoe MD Riverdale, Md.</b>						ADDRESS <b>F. Gasch's Sons Hyattsville, Md.</b>															
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Oct 11, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>				23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor Pro Geo Md.</b>													
24. FUNERAL DIRECTOR <b>F. Gasch's Sons Hyattsville, Md.</b>						25a. REC'D BY REGISTRAR DATE <b>OCT 14 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>													



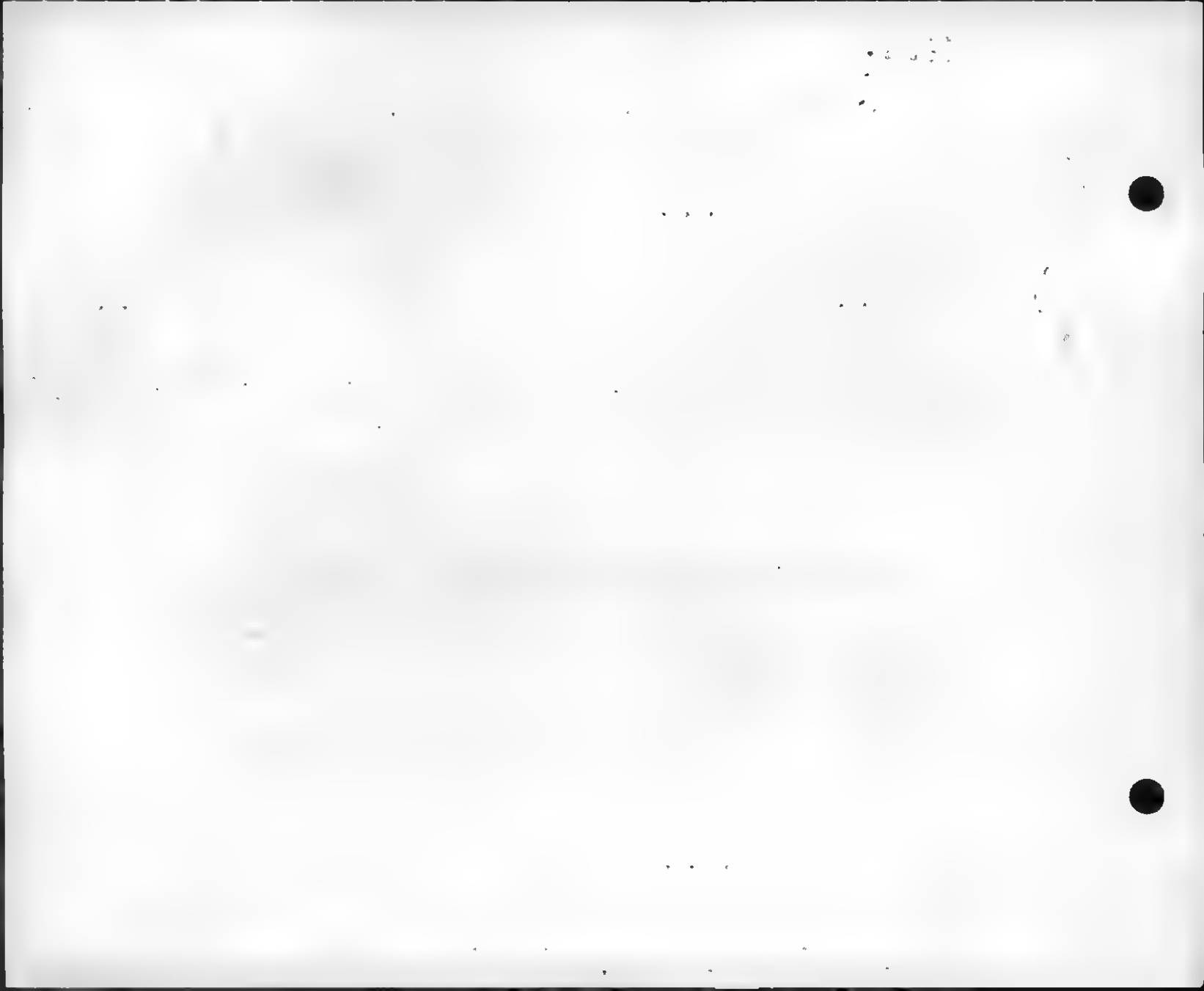


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
30M REV 1/68

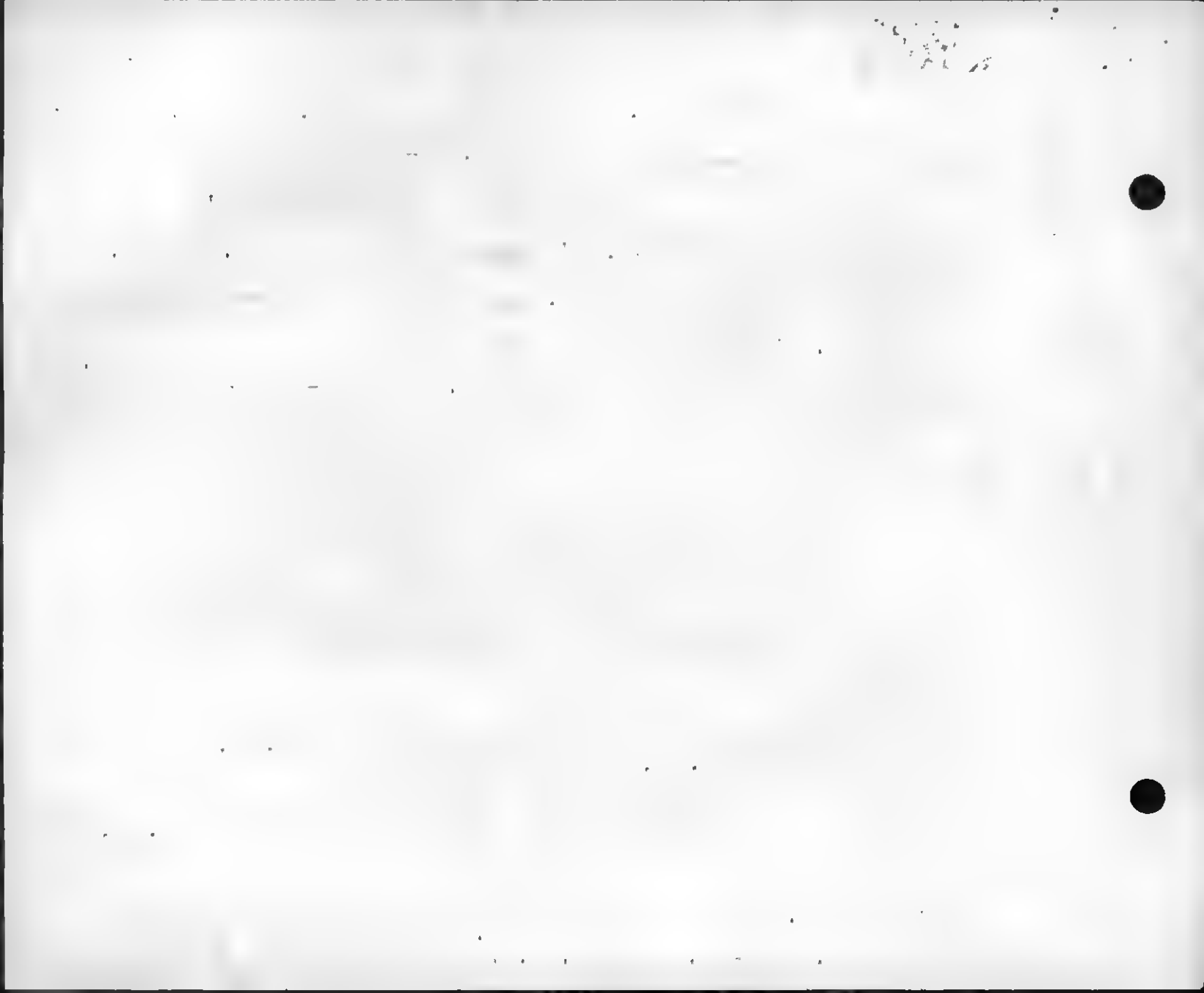
MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or print)		First <b>Louis</b>		Middle <b>W.</b>		Last <b>Redmond, Sr.</b>		2c. DATE OF DEATH Month <b>October</b> Day <b>15</b> Year <b>1968</b>		2b HOUR <b>5 P.M.</b>
3. SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>12/4/1888</b>		6. AGE (In years last birthday) <b>79</b> YRS		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS HOURS <b></b> MIN <b></b>
7a BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince Georges</b> Md.				
10. CITY OR TOWN OF DEATH <b>Glenn Dale</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Glenn Dale Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Florist</b>				
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>D.C.</b>		13b COUNTY <b>Washington</b>		13c CITY OR TOWN <b>Washington</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>51 Todd Place, N.E.</b>		
14. FATHER'S NAME First <b>James</b> Middle <b>E.</b> Last <b>Redmond</b>		15. MOTHER'S MAIDEN NAME First <b>Mary</b> Middle <b></b> Last <b>Summers</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) <b>NO</b> (If yes give war or dates of service)		16b SOCIAL SECURITY NO <b>577-07-8839</b>		17 INFORMANT <b>Louis W. Redmond, Jr.</b> Address <b>3408 55th Ave. Cheverly, Md.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bilateral lower lobar pneumonia</b>										<b>4 days</b>
DUE TO, OR AS A CONSEQUENCE OF <b>Pulmonary emphysema &amp; respiratory insufficiency</b>										<b>years</b>
DUE TO, OR AS A CONSEQUENCE OF <b>Pulmonary tuberculosis</b>										<b>6 years</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Arteriosclerotic heart disease with myocardial infarction (1962)</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE, BUILDING, ETC.		21f LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that <del>he</del> (this hospital) attended the deceased from <b>10/11/</b> , 19 <b>68</b> , to <b>10/15/</b> , 19 <b>68</b> , that <del>he</del> (we) last saw the deceased alive on <b>10/15/</b> , 19 <b>68</b> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>it</del> (we) (did) (did not) view the body after death.										
22b SIGNATURE <i>Moe Weiss</i>		DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>10/15/1968</b>				
22d. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M.D.</b>		22e. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Maryland</b>								
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE <b>10-18-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Prospect Hill Cemetery</b>		23d LOCATION (City or Town) (County) (State) <b>Washington, D. C.</b>				
24. FUNERAL DIRECTOR <b>Warner E. Humphrey, Inc.</b>		ADDRESS <b>8434 Ga. Ave.</b>		25a. REC'D BY REGISTRAR <b>Sil. Sp.</b>		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE <b>OCT 21 1968</b>		



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please to have carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
<div style="display: flex; justify-content: space-between;"> <span>14935</span> <span>CERTIFICATE OF DEATH</span> <span>14945</span> </div>										
1 DECEASED-NAME (Type or print) <b>Charles T. Richards</b>					2a. DATE OF DEATH Month <b>Oct.</b> Day <b>30</b> Year <b>1968</b>			2b. HOUR <b>11:07</b> P.M.		
3 SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>Jan. 29-1893</b>			6. AGE (In years last birthday) <b>75</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George's</b> Md.				
10. CITY OR TOWN OF DEATH <b>Cheverly</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>DOA Prince Geo. Gen'l Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Retired Wash. Gas Co.</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) <b>Maryland</b>			13b. COUNTY <b>Prince George's</b>		13c. CITY OR TOWN <b>Mt. Rainier</b>		13d. INSIDE CITY, Y/N? <input type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <b>3414 Newton Street</b>	
14. FATHER'S NAME First <b>JOHN F.</b> Middle <b>Richards</b> Last					15. MOTHER'S MAIDEN NAME First <b>Ella</b> Middle <b>Stiger</b> Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT <b>John F. Richards</b> Address <b>Wash/28, DC</b> <b>3314- Boones Lane</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4109 Coronary Occlusion with Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>421</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State		
22a. I certify that (I) <del>(has been)</del> attended the deceased from <b>Oct 7, 1968</b> , to <b>Oct. 30, 1968</b> , that (I) <del>(was)</del> last saw the deceased alive on <b>Oct. 30, 1968</b> , and that in (my) <del>(own)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death.										
22b. SIGNATURE <b>Oliver B. Bond</b> M.D. DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>					22c. DATE SIGNED <b>Oct. 30, 1968</b>					
22d. PHYSICIAN'S NAME (Type) <b>OLIVER B. BOND M.D.</b>					22e. ADDRESS <b>6872 RIVERDALE ROAD LANHAM MARYLAND 20801</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Nov. 2-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland, Maryland</b>				
24. FUNERAL DIRECTOR <b>Simmons Bros. 1661-Gd. Hope Rd. S.E.</b> ADDRESS <b>Wash., D.C.</b>					24a. RECEIVED BY REGISTRAR <b>NOV 4 1968</b>		24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



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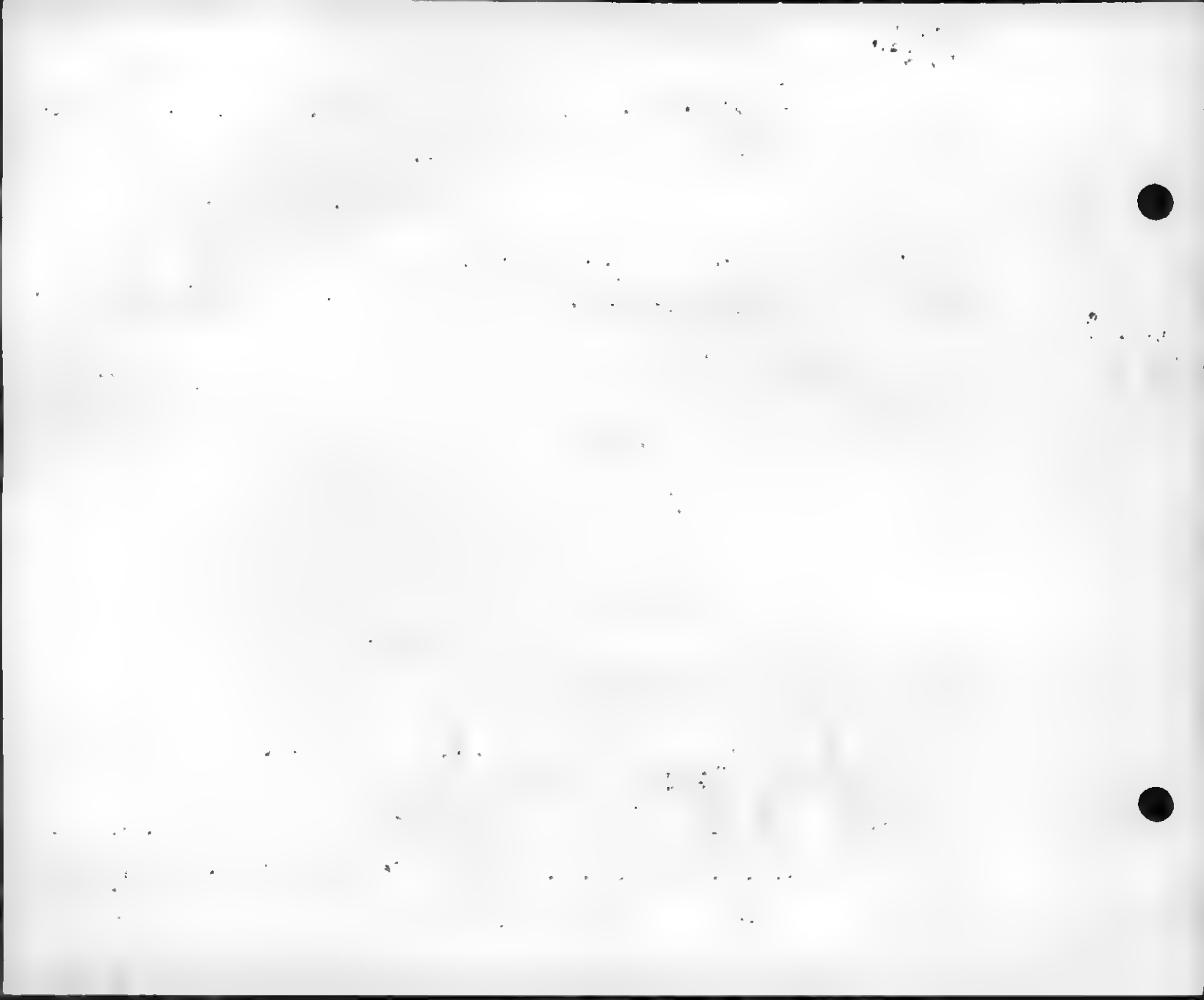
14936

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 5 Film 405 10-11-68

CERTIFICATE OF DEATH

14946

1. DECEASED NAME (Type or print)		First <b>Jacquelyn</b> Middle <b>J.</b> Last <b>Richardson</b>		2a. DATE OF DEATH Month <b>Oct.</b> Day <b>7</b> Year <b>1968</b>		2b. HOUR <b>4:20PM</b>	
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>12-30-31 1930</b>		6. AGE (In years last birthday) <b>37</b> YRS	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George's</b> Md.	
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo. Gen'l Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>none</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Prince George's</b>		13c. CITY OR TOWN <b>Upper Marlboro</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First <b>Harry</b> Middle <b>Richardson</b> Last <b>Richardson</b>		15. MOTHER'S MAIDEN NAME First <b>Martha</b> Middle <b>Klotz</b> Last <b>Klotz</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, on or unknown <input type="checkbox"/> NO <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO	
17. INFORMANT <b>Martha R. Richardson</b>		Address <b>7711 Old Forestville Rd.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREMIA</b> <b>5932</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CHRONIC RENAL INSUFF.</b> DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>600</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (this hospital) attended the deceased from <b>Oct. 6, 1968</b> , to <b>Oct. 7, 1968</b> , that (we) last saw the deceased alive on <b>Oct. 7, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (aid) (aided) view the body after death.							
22b. SIGNATURE <b>R B Ingham</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>						22c. DATE SIGNED <b>Oct. 8, 1968</b>	
22d. PHYSICIAN'S NAME (Type) <b>Roger B. Ingham, M. D.</b>				22e. ADDRESS <b>Prince George's Gen'l Hospital, Cheverly.</b>			
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10-10-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Epiphany Church Cemetery</b>		23d. LOCATION (City or Town) (County) <b>For-estville, Md. Pr. Geo.</b>	
24. FUNERAL DIRECTOR <b>Funeral Home 4308 Suitland Rd. S. E.</b>				25a. REC'D BY REGISTRAR DATE <b>OCT 11 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

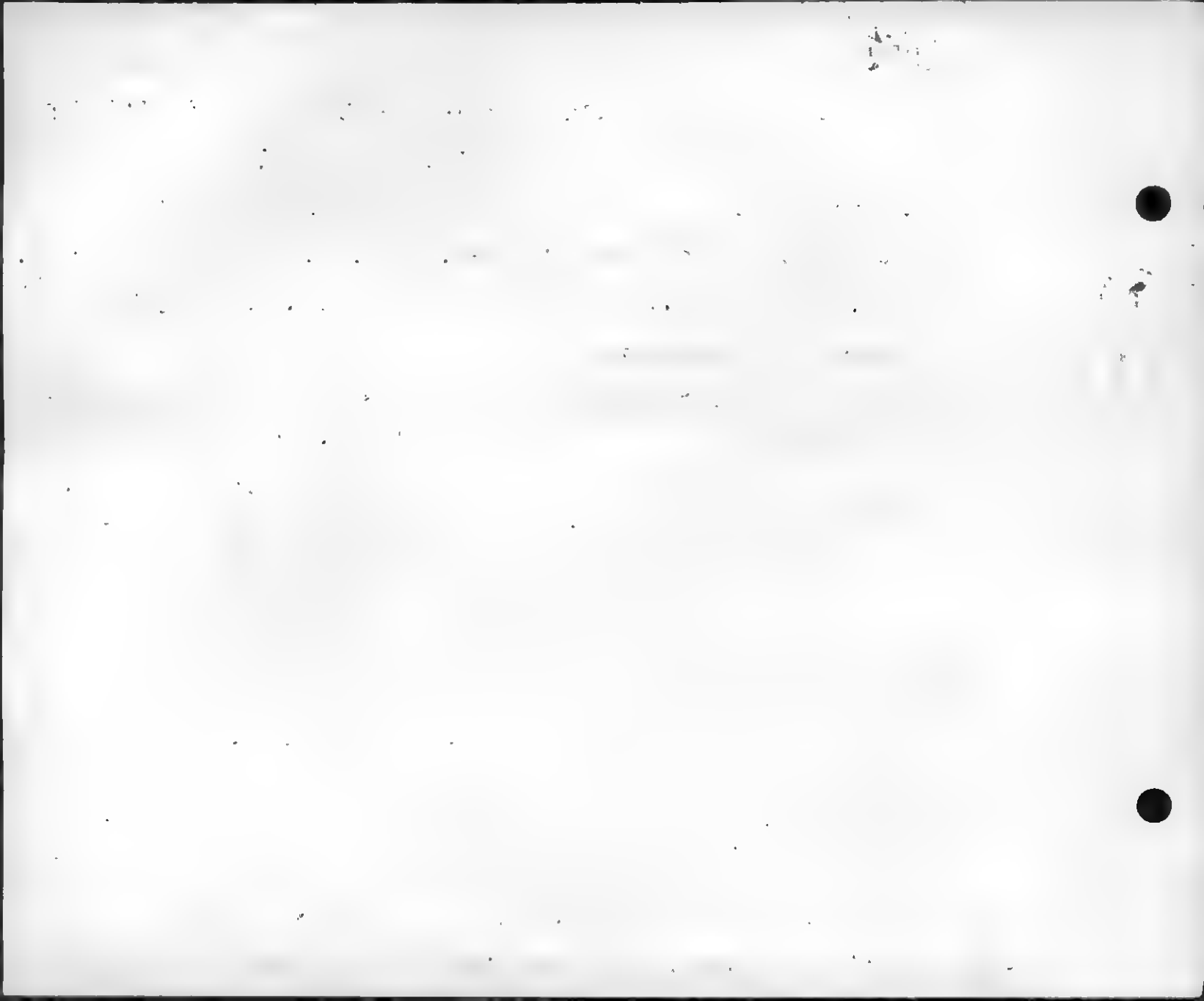


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VR 11-1-68  
304 REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
14937					14947						
1. DECEASED-NAME (Type or print) First Middle Last Paul Rayfield Riddlemoser					2a. DATE OF DEATH Month Day Year 10 8 68			2b. HOUR 6:25 M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH 9-23-89			6. AGE (In years last birthday) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md					
10. CITY OR TOWN OF DEATH Riverdale, Md.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Leland Memorial Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Salesman			12b. KIND OF BUSINESS OR INDUSTRY Packing Co.		
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE Md.			13b. COUNTY Prince George's			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Rt. #1 Box 304 A.			
14. FATHER'S NAME First Middle Last George Riddlemoser					15. MOTHER'S MAIDEN NAME First Middle Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO 216-07-1594			17. INFORMANT Address Paul W Riddlemoser Laurel Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RENAL FAILURE</u> <u>+129</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>CONGESTIVE HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ARTERIOSCLEROTIC C-V DISEASE</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u> <u>1 WEEK</u> <u>UNKNOWN</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>22 SEP, 1968</u> , to <u>8 OCT, 1968</u> , that (I) (we) last saw the deceased alive on <u>8 OCT, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>C.J. Houmann</u>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>8 OCT 1968</u>			
22d. PHYSICIAN'S NAME (Type) <u>C.J. HOUMANN</u>						22e. ADDRESS <u>RIVERDALE MD</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>10/11/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		23d. LOCATION (City or Town) (County) (State) <u>Colmar Manor PG Md</u>					
24. FUNERAL DIRECTOR <u>De Witt Donaldson Laurel, Md</u>						25a. REC'D BY REGISTRAR DATE <u>OCT 14 1968</u>		25b. REGISTRAR'S SIGNATURE <u>James J. Jones</u>			

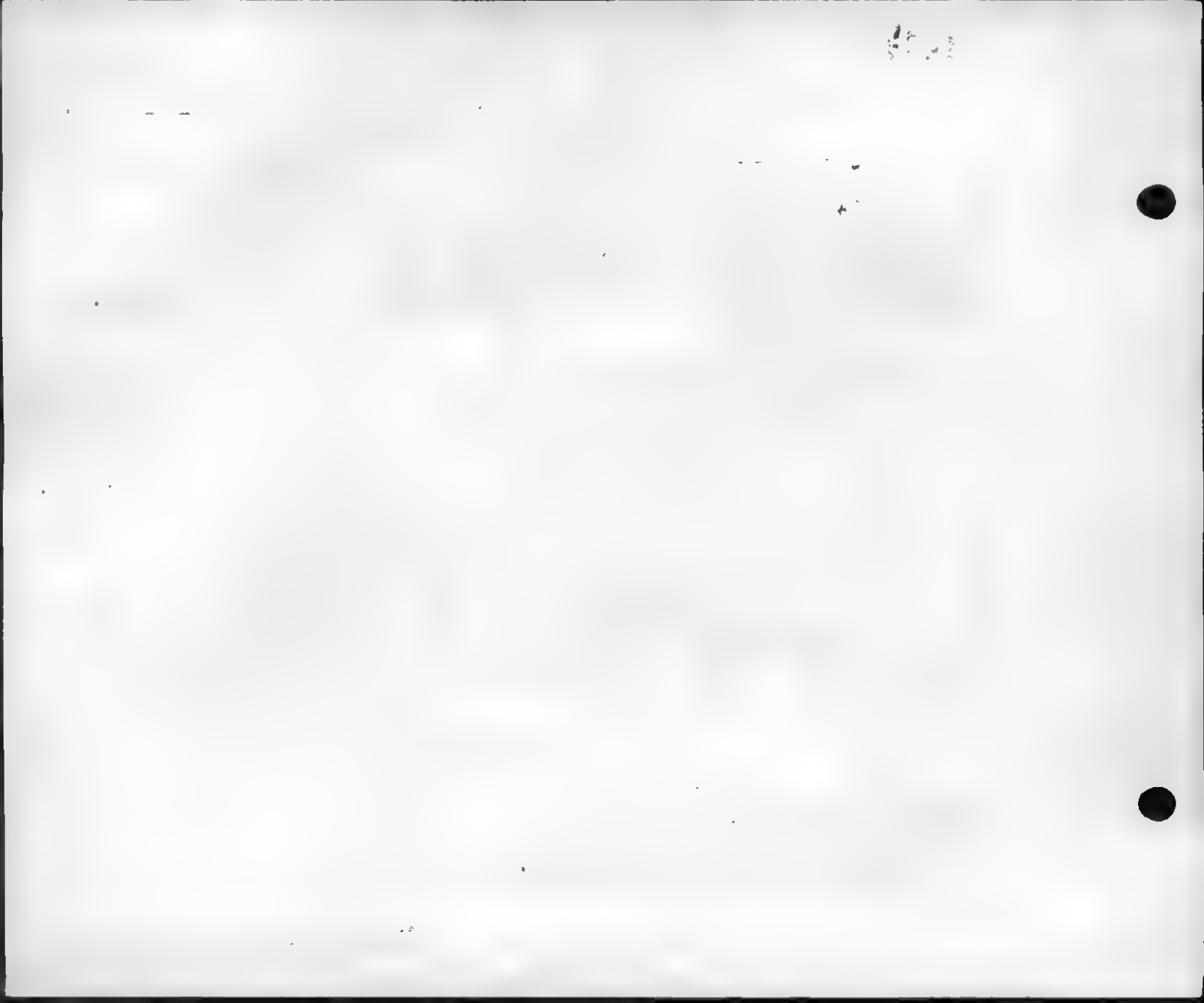




FOR STATE  
HEALTH-DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Pages 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> <p>14936</p> <p>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</p> <p>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</p> </div> <div> <p>14948</p> </div> </div>																							
1. DECEASED-NAME (Type or Print)						First		Middle		Last		2a. DATE KNOWN OF DEATH		2b. HOUR									
Hollie						Roberson						<input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> 10-19-68 1910:45PM		<input type="checkbox"/> 10-19-68 1910:45PM									
3 SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		2d. HOUR									
Male		Negro		6-3-1913		55 YRS		MONTHS		DAYS		Month 10 Day 19 Year 68 1910:45PM											
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>				9. COUNTY OF DEATH											
South Carolina				USA				W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				Prince George's Md.											
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY											
Cheverly				Prince George Hospital				Custodial															
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY - MITS?		13e. STREET AND NUMBER									
Maryland				Prince George's				Coral Hills				YES <input type="checkbox"/> NO <input type="checkbox"/>		1410 Boones Hill Rd.									
14. FATHER'S NAME				First				Middle				Last				5. MOTHER'S MAIDEN NAME							
John H. Roberson																Georgie A. Adams							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS				Ave., S.E.							
No								Georgie A. Peterson daughter				1306 S.C.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 1. DEATH WAS CAUSED BY:														1 week									
IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>																							
DUE TO, OR AS A CONSEQUENCE OF																							
(b) <u>Pulmonary tuberculosis</u>														over 1 yr.									
DUE TO, OR AS A CONSEQUENCE OF																							
(c)																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																							
0021																							
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?											
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)															
CAUSE OF DEATH				HOUR A.M. P.M. 19																			
21d. INJURY OCCURRED				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No				City or Town				County				State			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>																							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE						CHIEF MED. CAL. EXAMINER <input type="checkbox"/>						22b. DATE SIGNED											
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						10-20-68											
John Kehoe MD						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						ADDRESS (Street, city, town, or county)											
Riverdale, Md.																							
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town)				(County) (State)							
Burial				10/25/68								Edgefield, South Carolina											
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR						25b. REGISTRAR'S SIGNATURE											
Stewart Funeral Home 4001 Benning Rd., N.E.						DATE OCT 25 1968						Charles Judge											



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-13. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

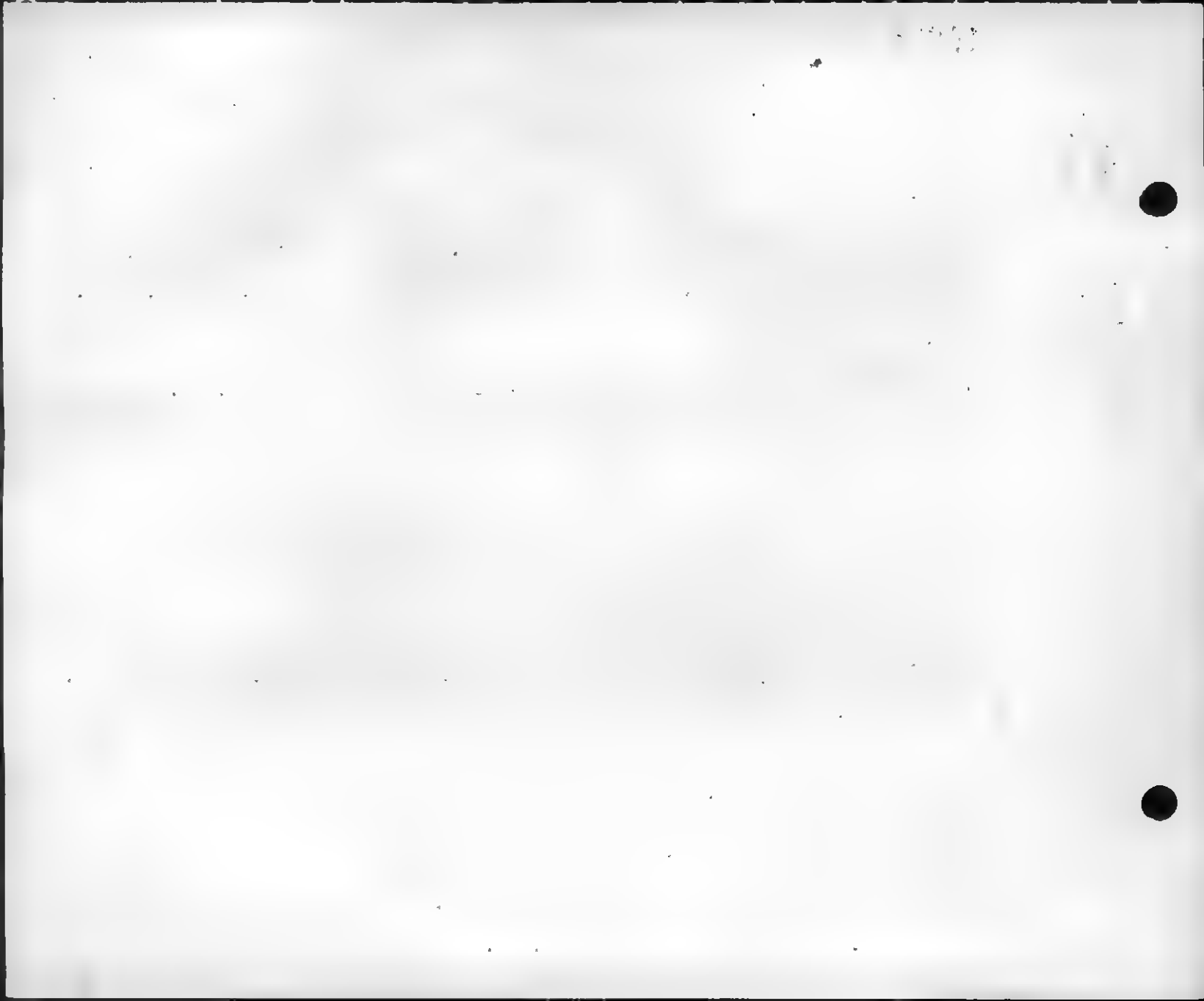
VR A15ME (5)  
10M REV. 1/68

14939

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14949

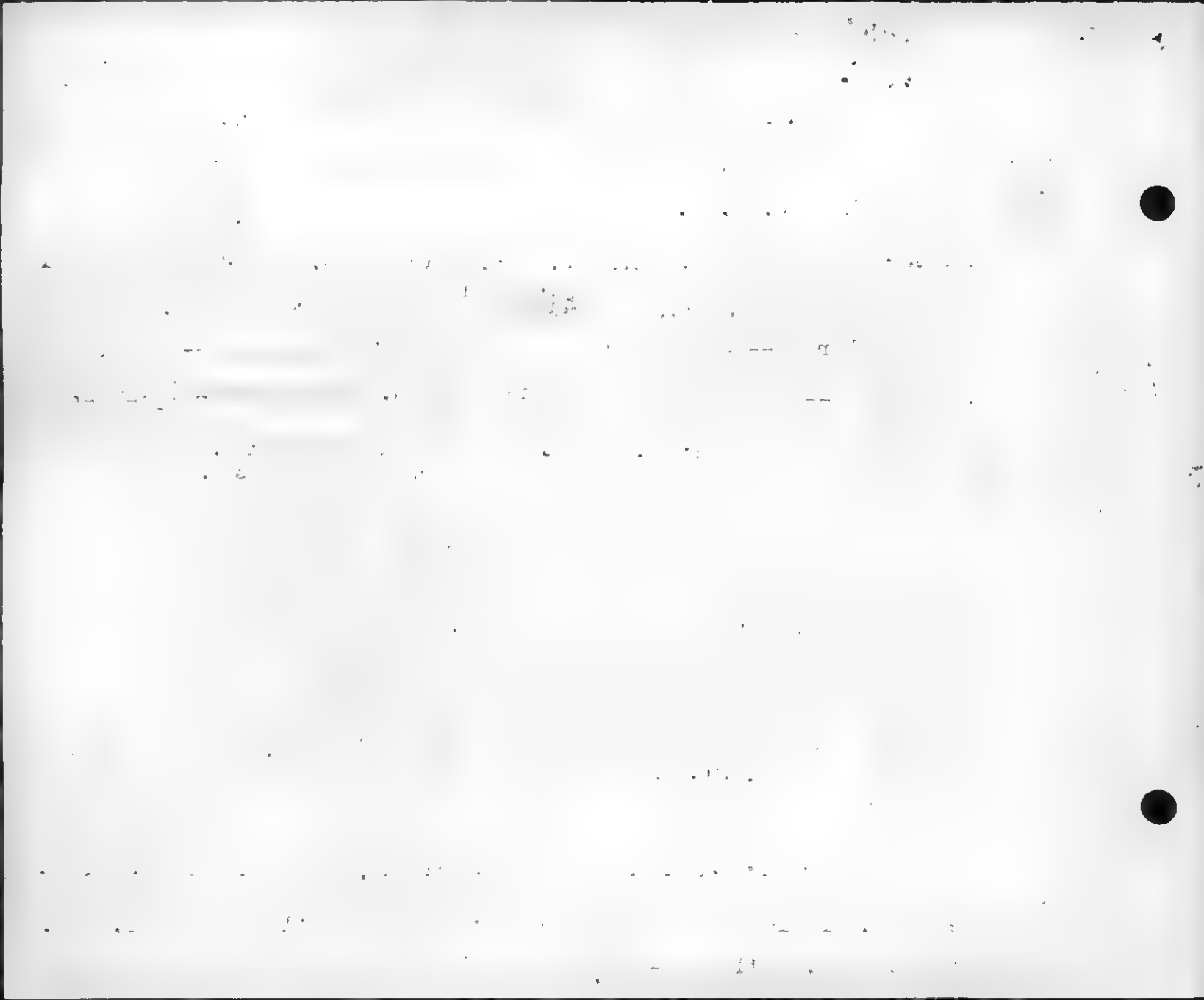
1 DECEASED NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 10/18/68 19 8:20A.M.			2b HOUR
Alan Francis Robins									
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year	2d HOUR
male	white	1/6/1928	40 YRS					10 18 1968	9:15AM
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH			
Washington D C		USA				Prince George's			Md
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY	
Lewisdale		Driveway of 6640 23rd ave.				Electrician		Railroad	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN	13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e STREET AND NUMBER		
Md			Pro Geo		Lanham		6884 Riverdale, Road.		
14. FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			
Thomas D Robins						Marjorie Denslow			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS	
yes			W W II		Thomas D Robins			Lanham, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 455 X Gun shot wound of head DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) 176 X									
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year HOUR A.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)				
CAUSE OF DEATH			8:20A P.M. 10/18/68		Shot self in head with 12 gauge shot gun.				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County	State
		Driveway of 6640 23rd ave		Lewisdale		Prince George's		Maryland	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspect an <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
John Kehoe MD			Riverdale, Md			ASS STANT MEDICAL EXAMINER <input type="checkbox"/>		10/18/68	
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE	23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)
Burial		10/21/68	Ft Lincoln Cemetery		Colmar Manor Pro Geo				Md.
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
F. Gasch's Sons Hyattsville, Md.					OCT 22 1968		Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
Item #5,6, Film 3406 11/20/68 km CERTIFICATE OF DEATH															
14950															
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR						
Adolph			Rodenhauer			Oct., 8 1968			4 15AM						
3 SEX		4 RACE		5. DATE OF BIRTH			6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF OVER 24 HRS				
Male		White		January 27, 1905			63 YRS.		MONTHS DAYS HOURS MIN						
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH						
New York			U. S. A.						Pr. Geo.			Md			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY			
Cheverly				Pr. Geo., Gen. Hosp.				(Fireman) Retired				Govmt Hospital			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN		13d. INS DE CITY, J.M.T.S?		13e. STREET AND NUMBER			
Maryland				Pr. Geo.				Lanham		YES <input type="checkbox"/> NO <input type="checkbox"/>		5519 Belya St.			
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last											
Peter -- Rodenhauer				Margaretha -- Voll											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO.				17 INFORMANT Address				Same as Items			
No --								Anneliese M. Rodenhauer-13e-13-c							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))															
PART I. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) <u>Myocardial Hypertrophy, severe, (750)grms.</u>															
4290 DUE TO, OR AS A CONSEQUENCE OF with heart failure.															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.															
(b) DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)															
4															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
Oct. 4, 1968			Obstructive Jaundice			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			Yes						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
			19												
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC			21f. LOCATION Street or R.F.D. No.			City or Town			County		State	
22a. I certify that (I) <del>physician</del> attended the deceased from <u>1-1</u> , 19 <u>64</u> , to <u>Oct. 8</u> , 19 <u>68</u> , that (I) <del>last</del> saw the deceased alive on <u>Oct. 8</u> , 19 <u>68</u> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>did</del> (did not) view the body after death.															
22b. SIGNATURE <u>A. Reitz</u>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <u>10-9-68</u>						
22d. PHYSICIAN'S NAME (Type) <u>Aaron Deitz, M. D.</u>						22e. ADDRESS <u>Prince George's Plaza, Hyattsville, Md.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)						
Cremation			10/10/68			Cedar Hill Crematory			Suitland PrGeo. Md.						
24. FUNERAL DIRECTOR ADDRESS <u>Ritchie Bros. Fun'l Home- Upper Marlboro Md.</u>						25a. REC'D BY REGISTRAR DATE <u>OCT 14 1968</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>						



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14942

CERTIFICATE OF DEATH

14951

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u>		c. LENGTH OF STAY IN IB <u>Hours</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9714 51st Avenue</u>		d. STREET ADDRESS <u>6310 51st Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Edna</u> Middle <u>Florence</u> Last <u>Rogers</u>		4. DATE OF DEATH Month <u>October</u> Day <u>16</u> Year <u>1968</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/23/1896</u>
9. AGE (In years last birthday) yrs <u>72</u>		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Trenton Turner</u>		14. MOTHER'S MAIDEN NAME <u>Ella Hitt</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>577054310B</u>	
17. INFORMANT <u>Andrew C Rogers</u>		Address <u>same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HYPOSTATIC PNEUMONIA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARCINOMA ABDOMINAL</u> DUE TO (c) <u>CARCINOMA BLADDER</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 yrs</u> <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>1810</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 10, 1968</u> , to <u>Oct 15, 1968</u> , that (I) (we) last saw the deceased alive on <u>Oct 15, 1968</u> , and that death occurred at <u>3 A.M.</u> from causes on and on the date stated above.			
22a. SIGNATURE <u>Richard F. Shaw</u>		22b. DATE SIGNED <u>Oct 16 1968</u>	
22c. PHYSICIAN'S NAME (Type) <u>DR RICHARD F. SHAW</u>		22d. ADDRESS <u>1324 - Michigan Ave. NE</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>10/19/1968</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery Colmar Manor Maryland</u>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <u>alley's Funeral Home Mt. Rainier, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 18 1968</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

24  
x  
x



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14942

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14952

1. DECEASED-NAME (Type or print) <b>Lucy</b>			First Middle Last			2a. DATE OF DEATH Month <b>10</b> Day <b>14</b> Year <b>68</b>			2b. HOUR <b>2:35</b> P.M.		
3 SEX <b>Female</b>			4 RACE <b>Negro</b>			5 DATE OF BIRTH <b>6-18-1890</b>			6 AGE (In years last birthday) <b>78</b> YRS.		
7a. BIRTHPLACE (State or foreign country) <b>D.C.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH <b>Prince George's</b> Md.		
10. CITY OR TOWN OF DEATH <b>Hyattsville</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>6500 Riggs Rd. Hyattsville</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Res. before admission) STATE <b>D.C.</b>			13b. COUNTY <b>Washington</b>			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>4926 3rd St. N.W.</b>		
14. FATHER'S NAME <b>Archie</b>			First Middle Last			15. MOTHER'S MAIDEN NAME <b>SARAH</b>			First Middle Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO. <b>571-01-9469</b>			17 INFORMANT <b>Daughter - Earlene Miser</b>			Address <b>-4926 3rd St. N.W.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4379 Congestive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Generalized &amp; Cerebral arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>337X</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Cerebral Vascular Accident</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE, BUILDING, ETC.			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>9-6</b> , 19 <b>68</b> , to <b>10-14</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>10-14</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Elmer Rones</b>			M.D. DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>10-14-68</b>		
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS <b>3201 0 St. S.E.</b>								
23a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>10/18/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Harmony Memorial Park</b>			23d. LOCATION (City or Town) (County) (State) <b>Maryland</b>		
24. FUNERAL DIRECTOR <b>Stewart</b>			ADDRESS <b>Funeral Home-4001 Benning Rd.</b>			25a. REC'D BY REGISTRAR <b>N. OCT 17 1968</b>			25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		



14943

## CERTIFICATE OF DEATH

14953

1. DECEASED NAME (Type or print) <b>Timothy</b>		First		Middle		Last		2a. DATE OF DEATH Month <b>OCT</b> Day <b>7</b> Year <b>68</b>		2b. HOUR <b>8:20</b> AM	
3. SEX <b>MALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH <b>6 JUNE 1968</b>				6. AGE (In years last birthday) <b>4</b> YRS.		IF UNDER 1 YEAR MONTHS <b>4</b> DAYS <b>1</b>	
7a. BIRTHPLACE (State or foreign country) <b>PUERTO RICO</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>PRINCE GEORGE'S COUNTY MD.</b>					
10. CITY OR TOWN OF DEATH <b>ANDREW AFB</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MALCOLM GROW USAF HOSP</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>NA</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>NA</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>PUERTO RICO</b>				13b. COUNTY <b>Ramey AFB</b>		13c. CITY OR TOWN <b>Ramey AFB</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <b>117 W. STREET</b>	
14. FATHER'S NAME First <b>CHARLES</b> Middle <b>ALTON</b> Last <b>ROMAN</b>				15. MOTHER'S MAIDEN NAME First <b>CHRISTINE</b> Middle <b>LENA</b> Last <b>BRIGIDA</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. <b>NA</b>		17. INFORMANT <b>FATHER</b>		Address <b>117 W. ST. PUERTO RICO</b>			
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>pulmonary atresia &amp; pulmonary hypertension</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 d. 3 mo</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Sepsis</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR <b>AM</b> Month <b>Day</b> Year <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <b>30 Aug</b> , 19 <b>68</b> , to <b>8 Oct</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>27 Oct</b> , 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>R. Hintz</b>		MO <b>DEGREE</b>		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>8 Oct 68</b>	
22d. PHYSICIAN'S NAME (Type) <b>RAYMOND HINTZ, CAPT.</b>		22e. ADDRESS <b>MALCOLM GROW USAF Hosp Andrews</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10-9-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Long Island Mall Cm.</b>		23d. LOCATION (City or Town) <b>Farmingdale Long Island N.Y.</b>		(County)		(State)	
24. FUNERAL DIRECTOR <b>W. W. Chambers</b>		ADDRESS <b>5717-11th St. S.E.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>		DATE <b>OCT 10 1968</b>		25b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be exposed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

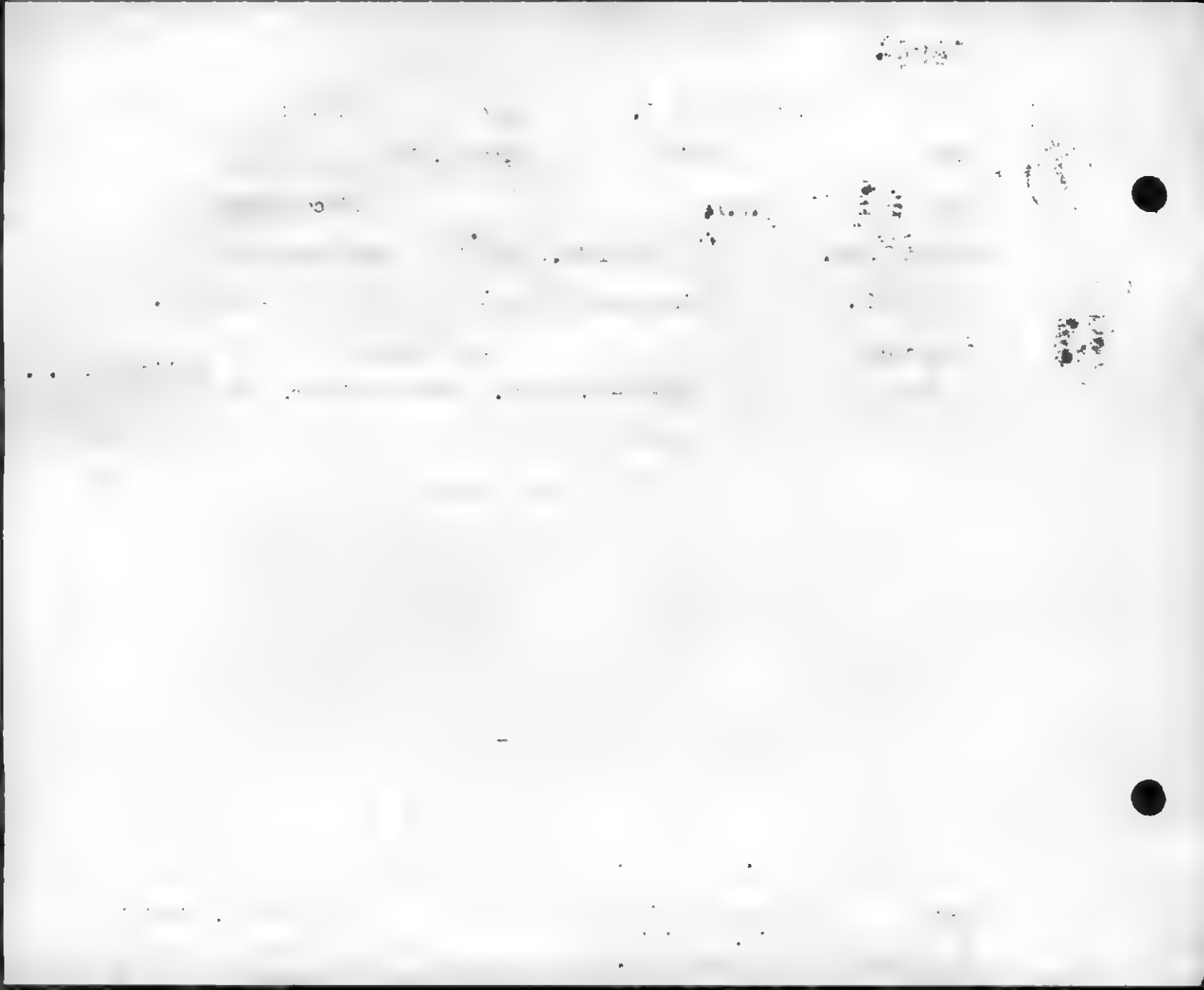
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

14944

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

14954

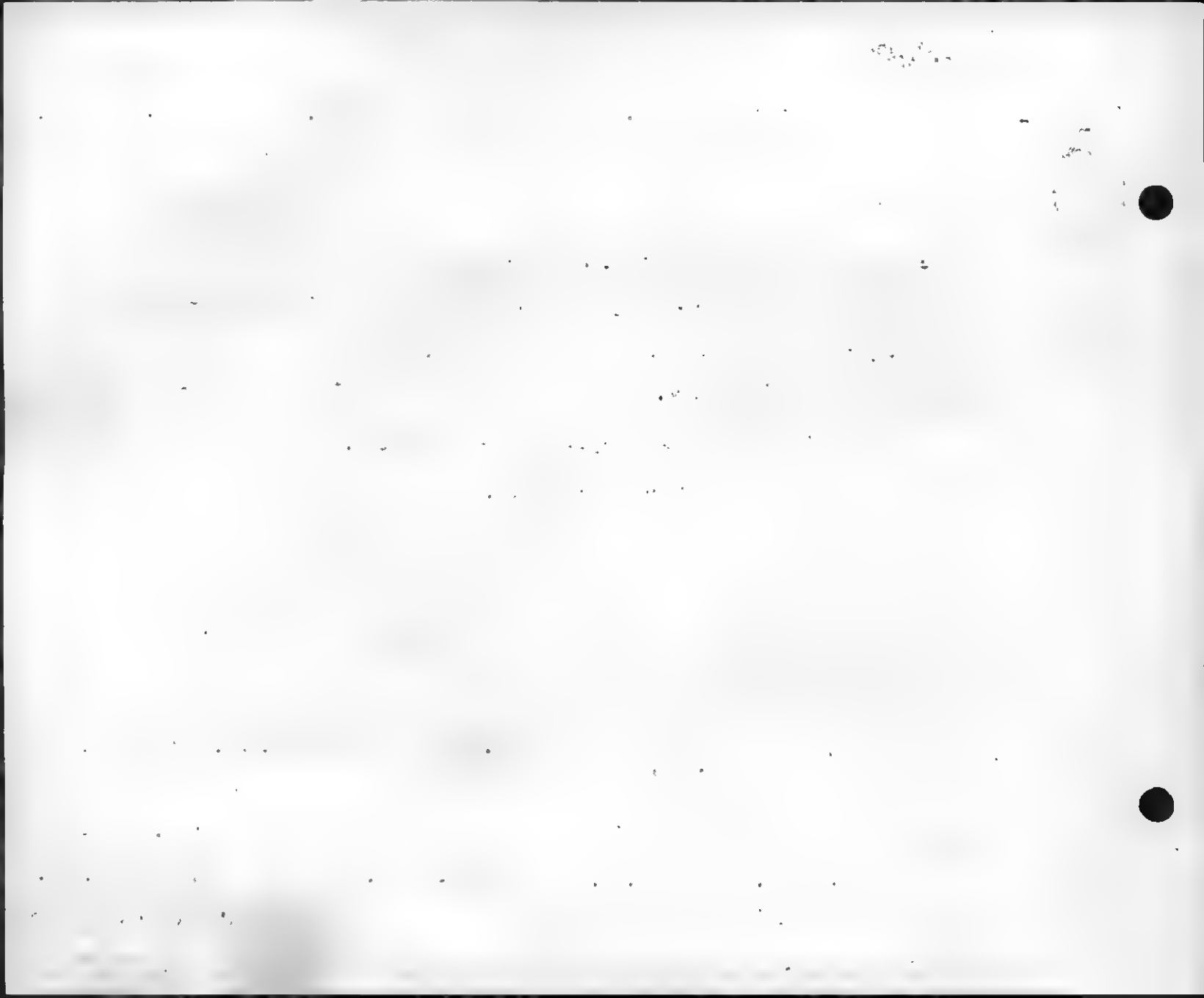
1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR	
Nathan			H.	Rose	October 15 1968		9:00 P.M.	
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (In years lost birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN
Male	White		May 19, 1909		59 YRS			
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
New York	U.S.A.				Prince George Md			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Oxon Hill, Md.		1107 Palmer Rd., Oxon Hill			Sheet Metal Wk.			
13a. USUAL RESIDENCE (Where deceased lived, if institut on. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER		
Md.		Prince George		Oxon Hill	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	1107 Palmer Rd.		
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last				
Sam Rose				Dora Cooper				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
No		066-01-0128		Mrs. Charles Ettinger, 9603 Cleveland Lane Washington, D.C.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction								1 Day
4109 DUE TO, OR AS A CONSEQUENCE OF								Years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								
(b) Generalized Atherosclerosis								
DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
4 years								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)				
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (1) (this hospital) attended the deceased from 3-14, 19 66, to 10-15, 19 68, that (4) (we) last saw the deceased alive on 10-15 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE				22c. DATE SIGNED				
Richard H. Dobson, M.D.				10/15/68				
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS				
Richard H. Dobson, M.D.				Brandywine, Maryland 20613				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		10/17/68		King David Cemetery		Falls Church, Virginia		
24. FUNERAL DIRECTOR				25a. REC'D BY REG. STRAR DATE		25b. REGISTRAR'S SIGNATURE		
The Demaine Funeral Homes, Inc. Alexandria, Virginia				OCT 21 1968		Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

14845										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										14955																																																											
1. DECEASED NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																																											
George M. Rountree										Oct. 22, 1968										1 P. M.																																																											
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years lost birthday)										IF UNDER 1 YEAR										IF UNDER 24 HRS.																													
Male										Caucasian										1898										70 YRS.										MONTHS										DAYS										HOURS										MIN.									
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH																																																	
Georgia										U.S.																				Prince George's										Md.																																							
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)										12b. KIND OF BUSINESS OR INDUSTRY																																																	
Cheverly										Prince Geo. Gen'l Hospital										Grocery Clerk										Giant Food Co																																																	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIM TST										13e. STREET AND NUMBER																																							
Maryland										Prince George's										Lanham										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										9133 6th Street																																							
14. FATHER'S NAME First Middle Last										15. MOTHER'S MAIDEN NAME First Middle Last																																																																					
George										Rountree										Unknown																																																											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown										16b. SOCIAL SECURITY NO.										17. INFORMANT										Address																																																	
No										Unknown										George A. Rountree										Same as #13																																																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																																					
PART I. DEATH WAS CAUSED BY:																																																																															
IMMEDIATE CAUSE (a)										Broncho-pneumonia - bilateral.																																																																					
DUE TO, OR AS A CONSEQUENCE OF																																																																															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b) Chronic Nephritis.																																																																					
DUE TO, OR AS A CONSEQUENCE OF										(c)																																																																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																																																															
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY?										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																																																	
																				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										Yes																																																	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																																											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																																											
22a. I certify that (X) (this hospital) attended the deceased from Oct. 13, 1968, to Oct. 22, 1968, that (X) (we) last saw the deceased alive on Oct. 22, 1968, and that (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did not) view the body after death.																																																																															
22b. SIGNATURE										22c. DATE SIGNED																																																																					
Roger B. Ingham										Oct. 22, 1968																																																																					
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																																																																					
Roger B. Ingham, M.D.										Prince Geo. Gen'l Hospital, Cheverly, Md.																																																																					
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																																																	
Burial										10-25-1968										Fort Lincoln										Colmar Manor, Maryland																																																	
24. FUNERAL DIRECTOR										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																																																											
W.W. Chambers Co. Riverdale, Md.										OCT 28 1968										J Charles Judge																																																											





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

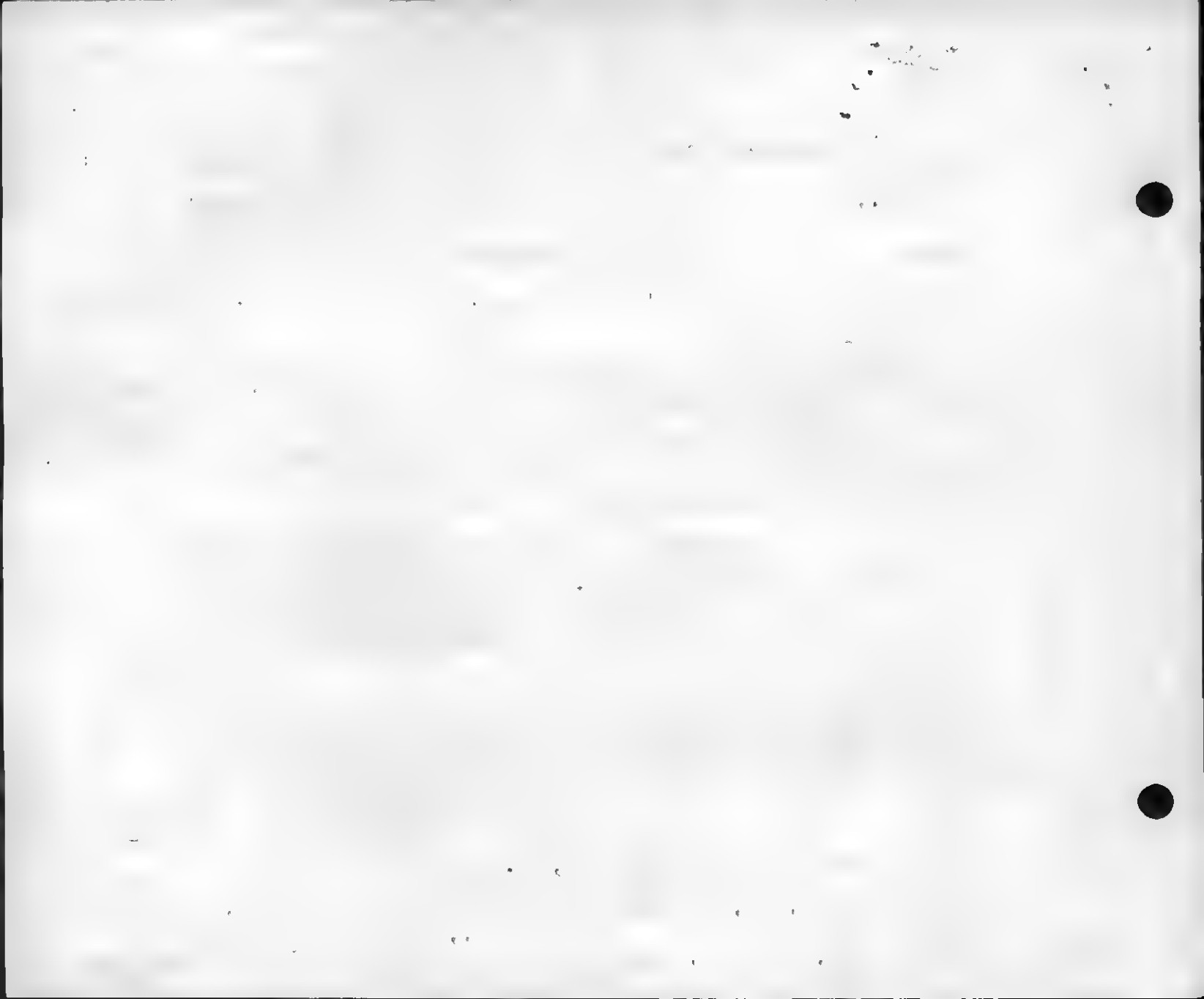
VR A15ME (5)  
10M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14946

14956

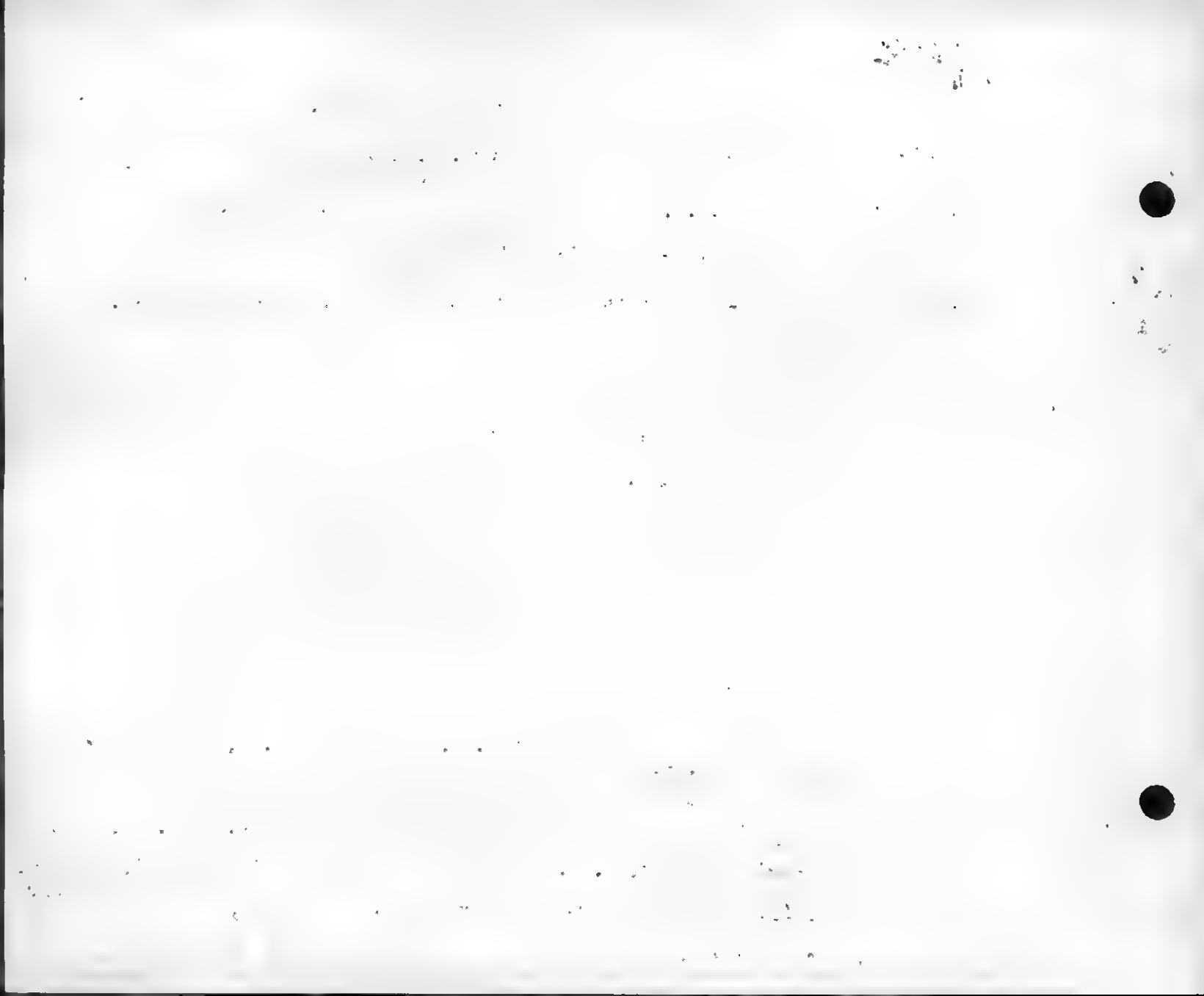
1 DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF ESTI DEATH MATED <input checked="" type="checkbox"/> 10-22-68 .9 8:05pm		2b HOUR
Ann		Mae		Ruth			
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 UNDER YEAR MONTHS DAYS HOURS MIN.	2c DATE PRONOUNCED DEAD	2d HOUR	
Female	White	Mrach 22-91	77 YRS		Month 10 Day 22 Year 68 8:25pm M		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH		
Wash., DC		USA		Prince George's			MD
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USJA. OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Cheverly		Prince George Hospital					
13a USJA. RESIDENCE (Where deceased lived, if institution admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Maryland		Prince George's		Marlowe Hgts.		2900 St. Clair Drive	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First Middle Last
John McDonald					Annie Groves		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No				Anna M. Beaton (Dau.) Same as # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure 112 / DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes over 1 yr
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4200 Diabetes - known over 5 yrs.							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED 10-23-68	
John Kehoe MD		Riverdale, Md.		ADDRESS (Street, city, town, or county)			
23a BURIAL, CREMATION REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)	
Burial		Oct. 25, 68		Cedar Hill Cemetery		Suitland, Maryland	
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR DATE		25b REGISTRAR'S SIGNATURE	
Simmons Bros.		Wash., DC		OCT 25 1968		J. Charles Judge	
Simmons Bros. 1661-Gd. Hope Road SE DC							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <span>14847</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>14957</span> </div>											
1. DECEASED NAME (Type or print) <b>Baby Girl Savoy</b>					2a. DATE OF DEATH <b>Oct. 9, 1968</b>			2b. HOUR <b>7:30PM</b>			
3. SEX <b>Female</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH <b>Oct. 5, 1968</b>			6. AGE (In years lost birthday) <b>5</b> YRS.				
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Prince George's Md.</b>				
10. CITY OR TOWN OF DEATH <b>Cheverly</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince George's Gen'l Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Prince George's</b>		13c. CITY OR TOWN <b>Coral Hills</b>		13d. INSIDE CITY (HMTS?) YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>1413 Boone Hill Rd.</b>		
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hyalin membrane of lungs with bronchopneumonia</b> <b>7669</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Breech Presentation</b> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (if either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that <del>he</del> (this hospital) attended the deceased from <b>Oct. 5, 1968</b> to <b>Oct. 9, 1968</b> , that <del>he</del> (we) lost <del>the</del> the deceased alive on <b>Oct. 9, 1968</b> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>he</del> (we) (did) <del>not</del> view the body after death.											
22b. SIGNATURE <b>HORACIO</b>					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>Oct. 11, 1968</b>			
22d. PHYSICIAN'S NAME (Type) <b>Bernardo Alvarado, M. D.</b>					22e. ADDRESS <b>Prince George's Gen'l Hospital, Cheverly.</b>						
23a. BURIAL, CREMATION, REMOVA (Specify)		23b. DATE <b>10/26/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Prince Geo. General Hosp.</b>			23d. LOCATION (City or Town) (County) <b>Cheverly, Maryland</b>				
24. FUNERAL DIRECTOR <b>William A. Parker, Assoc. Administrator</b>					25a. REC'D BY REGISTRAR DATE <b>OCT 29 1968</b>			25b. REG STRAR'S SIGNATURE <b>J Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

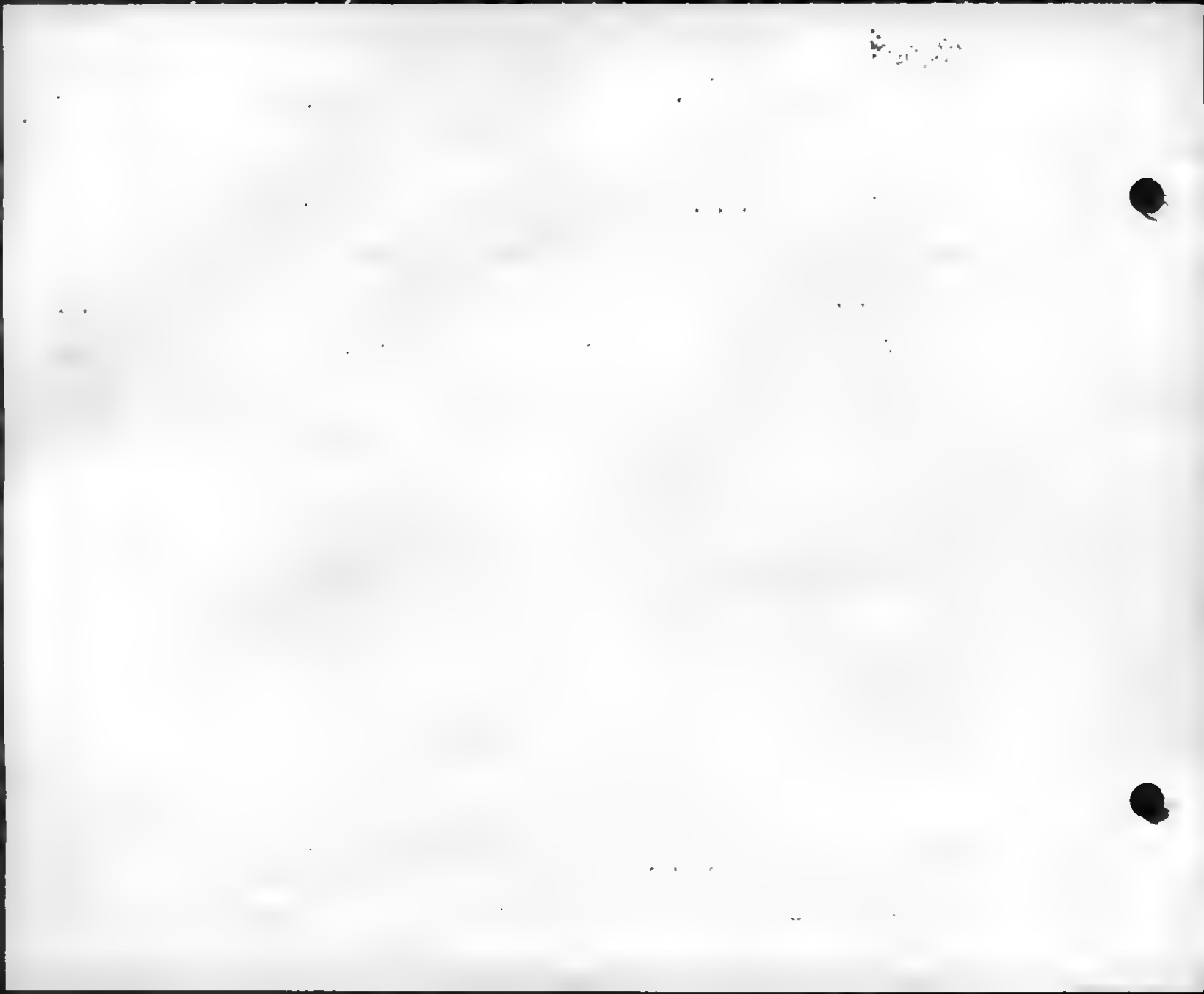
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14948

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

14958

1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
Myrtle				Schools				October		31	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. YRS.		8. MONTHS	
Female		Negro		7/4/1897		71					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Virginia		U.S.A.				Prince Georges				Md	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Glenn Dale		Glenn Dale Hospital		Unknown - Retired		--					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
D.C.				Washington				1619 1st Street, N.W.			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
Jacob		Crawford		Carrie		Tucker					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT		Address					
No		--		Decedent							
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY. Recurrent cerebrovascular accident with quadri-										3 mo.	
IMMEDIATE CAUSE (a) plegia											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c) Generalized arteriosclerosis										years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Arteriosclerotic & hypertensive cardiovascular disease; pulmonary tuberculosis, moderately advanced; right mastectomy 1964 for carcinoma of the breast											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by med. col. examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
		HOUR A.M. Month Day Year									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>											
22a. I certify that (X) (this hospital) attended the deceased from 10/18/1968, to 10/31/1968, that (X) (we) last saw the deceased alive on 10/31/1968, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) view the body after death.											
22b. SIGNATURE										22c. DATE SIGNED	
Moe Weiss										10/31/1968	
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS	
Moe Weiss, M.D.										Glenn Dale Hospital Glenn Dale, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		11-6-1968		Arlington National		Arlington, Virginia					
24. FUNERAL DIRECTOR										25a. REC'D BY REGISTRAR	
Molawis Schey Inc 424 R St NW										25b. REGISTRAR'S SIGNATURE	
										NOV 6 1968	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
304 REV. 1/68

<div style="display: flex; justify-content: space-between;"> <span>14849</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>14959</span> </div> <div style="text-align: center; font-weight: bold; font-size: 1.2em;">CERTIFICATE OF DEATH</div>													
1. DECEASED-NAME (Type or print) <b>Robert</b>				First Middle Last <b>Seeley</b>				2a. DATE OF DEATH Month <b>1</b> , Day <b>1968</b> Year <b>Oct.</b>				2b. HOUR <b>7:15 PM</b>	
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>March 4, 1905</b>				6. AGE (In years last birthday) <b>63</b> YRS.		7. UNDER 1 YEAR MONTHS <b>1</b> DAYS <b>1</b>		7. UNDER 24 HRS HOURS <b>15</b> MIN. <b>00</b>	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George's</b> Md							
10. CITY OR TOWN OF DEATH <b>Cheverly</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo.Gen'l Hospital</b>				12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired) <b>None</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Prince George's</b>		13c. CITY OR TOWN <b>Hyattsville</b>		13d. INSIDE CITY LIM. IS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>5102 Annapolis Road</b>					
14. FATHER'S NAME First Middle Last <b>Rodney W. Seeley</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Unknown</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>				16b. SOCIAL SECURITY NO <b>402-02-2221</b>		17. INFORMANT Name Address <b>None</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>massive Pulmonary embolization</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Diverticulitis with ruptured into abdominal cavity</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>causing peritonitis</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs.</b> <b>6 days?</b>													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>generalized atherosclerosis with atherosclerotic heart disease</b>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that <del>he</del> (this hospital) attended the deceased from <b>Sept. 23, 1968</b> , to <b>Oct. 1, 1968</b> , that <del>he</del> (we) last saw the deceased alive on <b>Oct. 1, 1968</b> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>he</del> (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>Faruk Ozer</b>				DEGREE <b>M.D.</b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10.2.68</b>					
22d. PHYSICIAN'S NAME (Type) <b>Faruk Ozer, M. D.</b>				22e. ADDRESS <b>Prince Geo.Gen'l Hospital, Cheverly, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)							
24. FUNERAL DIRECTOR <b>Thomas Bros</b>		ADDRESS <b>1661-Good Hope Rd SE</b>		25a. REC'D BY REGISTRAR <b>OCT 3 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR 1605 M			
INFANT MALE SKINNER						OCTOBER 11 1968						
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH 10 October 1968			6. AGE (In years last birthday) YRS.		7. UNDER YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH PRINCE GEORGES Md.						
10. CITY OR TOWN OF DEATH ANDREWS AFB			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Malcolm Grow USAF Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.			13b. COUNTY Prince Georges			13c. CITY OR TOWN Oxon Hill		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 2502 Clarion Road		
14. FATHER'S NAME First Middle Last Paul E Skinner				15. MOTHER'S MAIDEN NAME First Middle Last Joan V Anderson								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO (If yes give war or dates of service)		17. INFORMANT Address Father 9502 Clarion Dr. Oxon Hill, Md						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory distress syndrome</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 hrs 18 hrs		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
9a. DATE OF OPERATION		9b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <u>11 Oct 1968</u> , to <u>11 Oct 1968</u> , that (I) (we) last saw the deceased alive on <u>11 Oct 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Raymond L Hintz MD</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 11 Oct 68				
22d. PHYSICIAN'S NAME (Type) Raymond L Hintz				22e. ADDRESS Malcolm Grow USAF Hospital Andrews AFB, Washington, D.C. 20331								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Oct. 24, 1968		23c. NAME OF CEMETERY OR CREMATORY Arlington National			23d. LOCATION (City or Town) (County) (State) Arlington, Virginia					
24. FUNERAL DIRECTOR <u>C. M. James</u>				ADDRESS Murphy Funeral Home Arlington, Virginia 22204				25a. REC'D BY REGISTRAR DATE OCT 24 1968		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		



14952

CERTIFICATE OF DEATH

14961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. DECEASED NAME (Type or print) <b>JOAN VANCE SKINNER</b>			2a. DATE OF DEATH Month <u>21</u> Day <u>October</u> Year <u>1968</u>			2b. HOUR <u>4:35P</u> M				
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>June 30, 1936</b>		6. AGE (In years last birthday) <b>32</b> YRS.		IF UNDER 1 YEAR MONTHS <u>  </u> DAYS <u>  </u> HOURS <u>  </u> MIN <u>  </u>		
7a. BIRTHPLACE (State or foreign country) <b>Wyoming</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George's County</b> Md				
10. CITY OR TOWN OF DEATH <b>Andrews AFB</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Malcolm Grow USAF Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md</b>			13b. COUNTY <b>P G County</b>		13c. CITY OR TOWN <b>Oxon Hill</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>9502 Clarion Road</b>	
14. FATHER'S NAME First Middle Last <b>Gerald Anderson</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Nancy Vance</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes give year or dates of service) <b>Jun 60 - Jan 62</b>			16b. SOCIAL SECURITY NO <b>520-34-0150</b>		17. INFORMANT Address <b>Paul E Skinner, 9502 Clarion Rd, Oxon Hill</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MY POXEMIA &amp; SHOCK</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>SEPTIC PULMONARY EMBOLI</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>SUBDIAPHRAGMATIC ABSCESS</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>16x</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 DAY</b> <b>1 DAY</b> <b>2 WEEKS</b>	
19a. DATE OF OPERATION <b>17 OCT 68</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>DRAINAGE OF ABSCESS.</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>17 OCT 68</u> , 19 <u>68</u> , to <u>21 OCT 19 68</u> , that (I) (we) last saw the deceased alive on <u>21 OCT 19 68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Leonard R Farber MD</b> DEGREE <b>CAPT USAF MC</b>				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>21 OCT 68</b>				
22d. PHYSICIAN'S ADDRESS <b>Malcolm Grow USAF Hospital</b>				22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		23b. DATE <b>Oct. 24, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>			23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>			
24. FUNERAL DIRECTOR <b>C. M. Francis</b>				ADDRESS <b>Murphy Funeral Home</b> <b>Arlington, Virginia</b>			25a. REC'D BY REG STRAR DATE <b>OCT 24 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

100



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14952

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

14962

1 DECEASED-NAME (Type or print) <b>GEORGE WILSON SMITH</b>			2a DATE OF DEATH Month <b>OCTOBER</b> Day <b>31</b> Year <b>1968</b>			2b HOUR <b>7:15</b> <sup>A</sup> <sup>M</sup>				
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH <b>8-31-1906</b>		6 AGE (In years lost birthday) <b>62</b> YRS		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN <b></b>		
7a. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince Georges</b> Md.				
10. CITY OR TOWN OF DEATH <b>Hillcrest Heights</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>2421 Colebrook Dr.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>ret. U S Gov.</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>U S Gov.</b>	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b> 13b COUNTY <b>PRINCE GEORGES</b>			13c CITY OR TOWN <b>HILLCREST HGTS</b>		13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e STREET AND NUMBER <b>2421 COLEBROOK DRIVE</b>			
14. FATHER'S NAME First <b>George</b> Middle <b>W.</b> Last <b>Smith</b>			15 MOTHER'S MAIDEN NAME First <b>Annie</b> Middle <b>Freeland</b> Last <b></b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service) <b>Yes 7-15-42 - 1945</b>			16b SOCIAL SECURITY NO <b>579-22-3553</b>		17 INFORMANT <b>Agnes G. Smith</b>		Address <b>2421 C. Colebrook Dr.</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF <b></b> (c) <b></b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2</b> <b>Days</b>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>42-21</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <b></b> Month <b></b> Day <b></b> Year <b>19</b> P.M. <b></b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No <b></b> City or Town <b></b> County <b></b> State <b></b>						
22a. I certify that (I) (this hospital) attended the deceased from <b>8-31-68</b> , to <b>10-31-68</b> , that (I) (we) last saw the deceased alive on <b>10-31-68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>John J. Gandy M.D.</b>						DEGREE <b></b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>10/31/68</b>		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <b>2421 Colebrook Dr.</b>								
23a BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>11-4-68</b>		23c NAME OF CEMETERY OR CREMATORY <b>Resurrection Cemetery</b>		23d LOCATION (City or Town) (County) (State) <b>Clinton Pr. Geo. Md.</b>				
24. FUNERAL DIRECTOR <b>Robert E. Wilhelm Fun. Home</b>				ADDRESS <b>4308 Suitland Rd.</b>		25a. REC'D BY REGISTRAR <b>DATE NOV 6 1968</b>		25b REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH			2b. HOUR
Sophia		J.		Smith		Month 10 Day 18 Year 68			M		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female		White		5/26/75			93 YRS		MONTHS DAYS		HOURS M N
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		USA				Prince George Md					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Clinton, Md.			Fine View Gardens			Housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Md.			Pr. Geo.		Bladensburg				4110 Edmonston Avenue		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
Cornelius			Thistle			Julia Kensler					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address						
unknown			no		214-14-3686 Margaret Tolson, Clinton, Maryland 20735						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Cardiac Arrest											
4272 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
(b) CVA											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
		HOUR A.M. Month Day Year									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No		City or Town		County State	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> ot work <input type="checkbox"/>											
22a. I certify that (I) (this hospital) attended the deceased from 10/2, 1968, to 10/18, 1968, that (I) (we) lost the deceased alive on 10/18, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE								22c. DATE SIGNED			
Charles R. Lapin, M.D.											
22d. PHYSICIAN'S NAME (Type)								22e. ADDRESS			
Charles R. Lapin, M.D.								Clinton, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		Oct 22, 1968		Cedar Hill Cemetery		Suitland Pro Geo				Md.	
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
F. Gasch's Sons				Hyattsville, Md.				DATE		OCT 22 1968	
										Charles Judge	

X Blagensburg

x



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

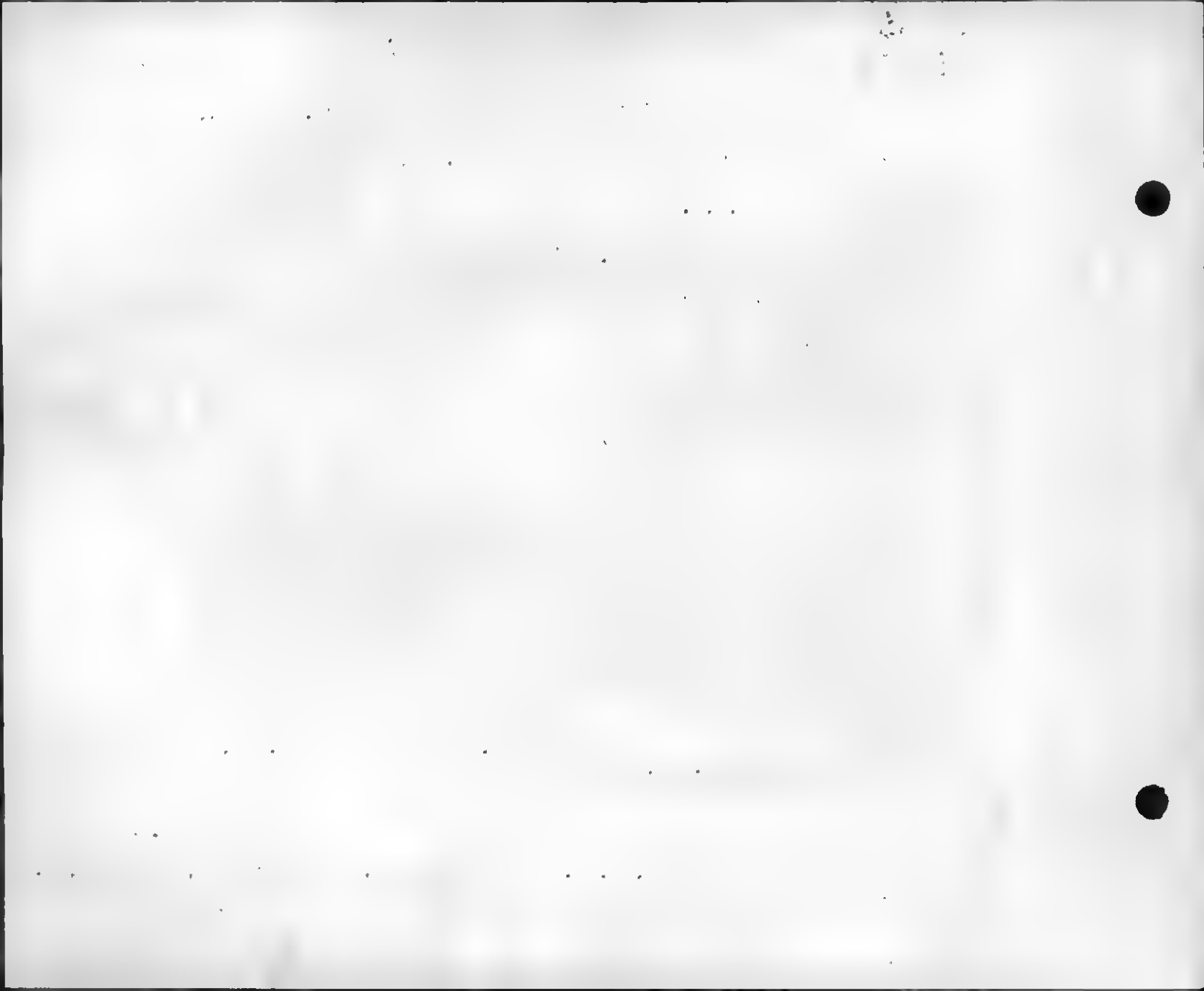
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14954

14964

1. DECEASED NAME (Type or print) <b>Baby</b>			First <b>Girl</b>			Middle <b>Spriggs</b>			Last			2a. DATE OF DEATH Month <b>Oct.</b> Day <b>24</b> Year <b>1968</b>			2b. HOUR <b>8:15AM</b>		
3. SEX <b>Female</b>			4. RACE <b>Caucasian</b>			5. DATE OF BIRTH <b>Oct. 24, 1968</b>			6. AGE (In years last birthday) <b>YRS</b>			IF UNDER 1 YEAR MONTHS <b>3</b> DAYS <b>45</b>			IF UNDER 24 HRS HOURS <b>3</b> MIN <b>45</b>		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Prince George's</b>			Md.					
10. CITY OR TOWN OF DEATH <b>Cheverly</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo.Gen'l Hospital</b>			2a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Prince George's</b>			13c. CITY OR TOWN <b>Seat Pleasant</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>6517 C Street</b>					
14. FATHER'S NAME First <b>Ernest</b>			Middle <b>Leroy</b>			Last <b>Spriggs</b>			15. MOTHER'S MAIDEN NAME First <b>Dorothy</b>			Middle <b>Yvonne</b>			Last <b>DeVore</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO. (If give year or dates of service)			17. INFORMANT			Address								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Immaturity</b> <b>777X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State											
22a. I certify that <del>xx</del> (this hospital) attended the deceased from <b>Oct. 24, 1968</b> , to <b>Oct. 24, 1968</b> , that <del>xx</del> (we) last saw the deceased alive on <b>Oct. 24, 1968</b> , and that in <del>our</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>xx</del> (we) (did not) view the body after death.																	
22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type) <b>Bernardo Alvarado, M. D.</b>			22e. ADDRESS <b>Prince Geo.Gen'l Hospital, Cheverly, Md.</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE <b>11-2-68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Prince George's General</b>			23d. LOCATION (City or Town) (County) (State) <b>Cheverly, Maryland</b>								
24. FUNERAL DIRECTOR <b>Harry A. Penn, Jr., Administrator</b>			ADDRESS <b>Hospital</b>			25a. REC'D BY REGISTRAR <b>NOV 6 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>								

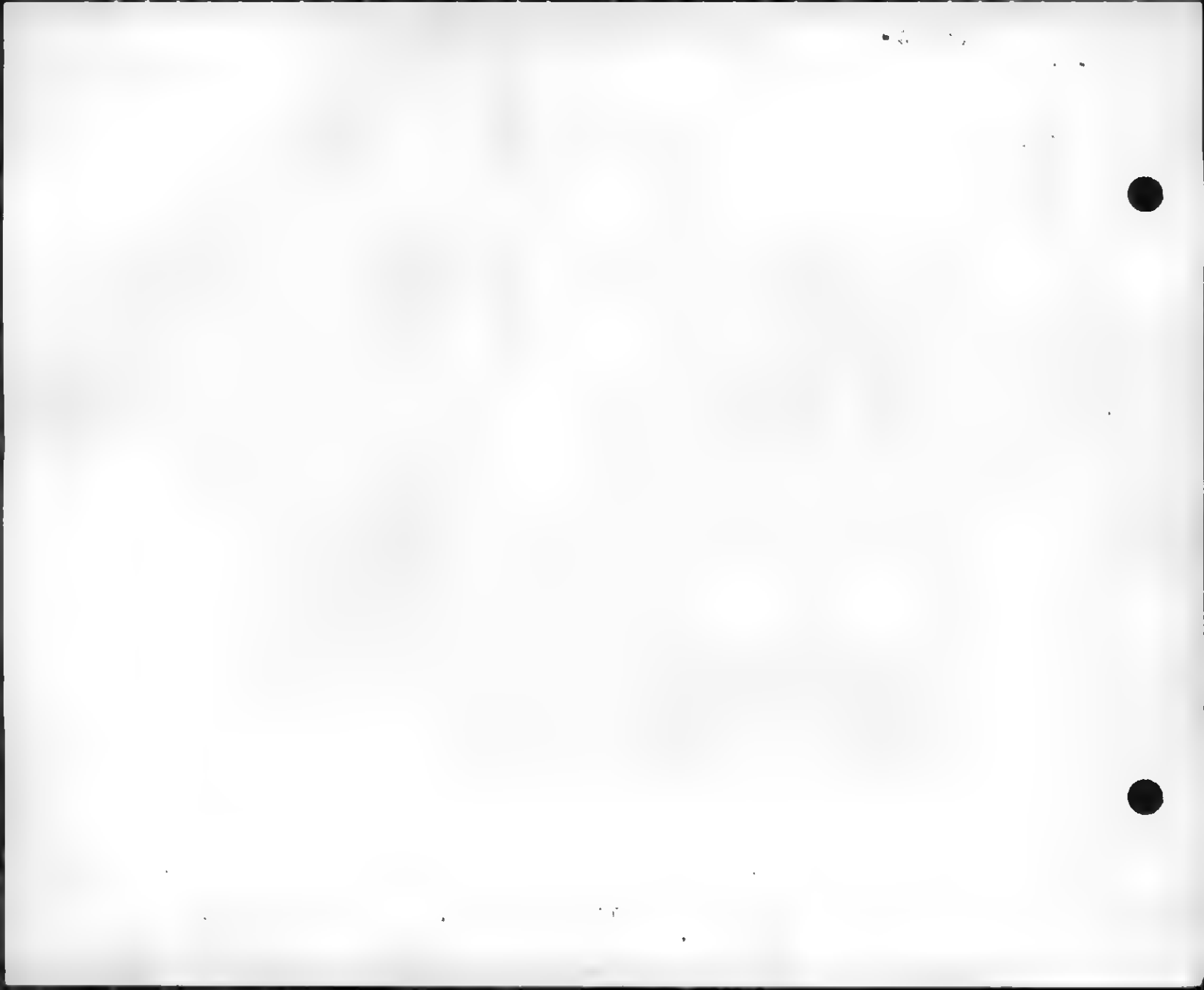


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
304a REV. 1-7-68

14955		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		14965	
JUANITA			CERTIFICATE OF DEATH		
1. DECEASED NAME (Type or print) <sup>First</sup> <u>JUANITA</u> <sup>Middle</sup> <u>MOORE</u> <sup>Last</sup> <u>STANSELL</u>			2a. DATE OF DEATH <u>October</u> <sup>Month</sup> <u>27</u> , <sup>Day</sup> <u>1968</u> <sup>Year</sup>		2b. HOUR <u>7:10</u> <sup>P</sup>
3. SEX <u>Female</u>	4. RACE <u>Caucasian</u>	5. DATE OF BIRTH <u>September 25, 1908</u>		6. AGE (In years last birthday) <u>60</u> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) <u>Virginia</u>	7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <u>Prince George</u> Md		
10. CITY OR TOWN OF DEATH <u>Camp Springs</u>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Malcolm Grow USAF Hosp</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Registered Nurse</u>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u>		13b. COUNTY <u>Prince Geo</u>	13c. CITY OR TOWN <u>Camp Springs</u>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <u>4409 Simmons Lane</u>
14. FATHER'S NAME <sup>First</sup> <u>James</u> <sup>Middle</sup> <u>Malcolm</u> <sup>Last</sup> <u>Wilfong</u>			15. MOTHER'S MAIDEN NAME <sup>First</sup> <u>Fanny</u> <sup>Middle</sup> <u>Wiseman</u> <sup>Last</sup>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <u>579-58-1104</u>		17. INFORMANT <u>4409 Simmons Lane</u> <u>Barbara Dodge</u> <u>Camp Springs, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> <u>4109</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>4201</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>October 24, 1968</u> , to <u>October 27, 1968</u> , that <u>(X)</u> (we) last saw the deceased alive on <u>October 24, 1968</u> , and that in <u>(our)</u> (my) opinion death occurred on the date and hour and from the causes stated above. <u>(X)</u> (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Michael S. Goldstein</u> DEGREE				22c. DATE SIGNED <u>October 27, 1968</u>	
22d. PHYSICIAN'S NAME (Type) <u>MICHAEL S. GOLDSTEIN</u>				22e. ADDRESS <u>Malcolm Grow USAF Hospital</u> <u>Andrews AFB, Washington, D.C. 20331</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>10-31-68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl.</u>	
23d. LOCATION (City or Town) <u>Arlington, Va</u>		23e. LOCATION (County) (State) <u>(County) (State)</u>			
24. FUNERAL DIRECTOR <u>Simmons Bros.</u>		ADDRESS <u>Wash D.C.</u>		25a. REC'D BY REGISTRAR <u>OCT 30 1968</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

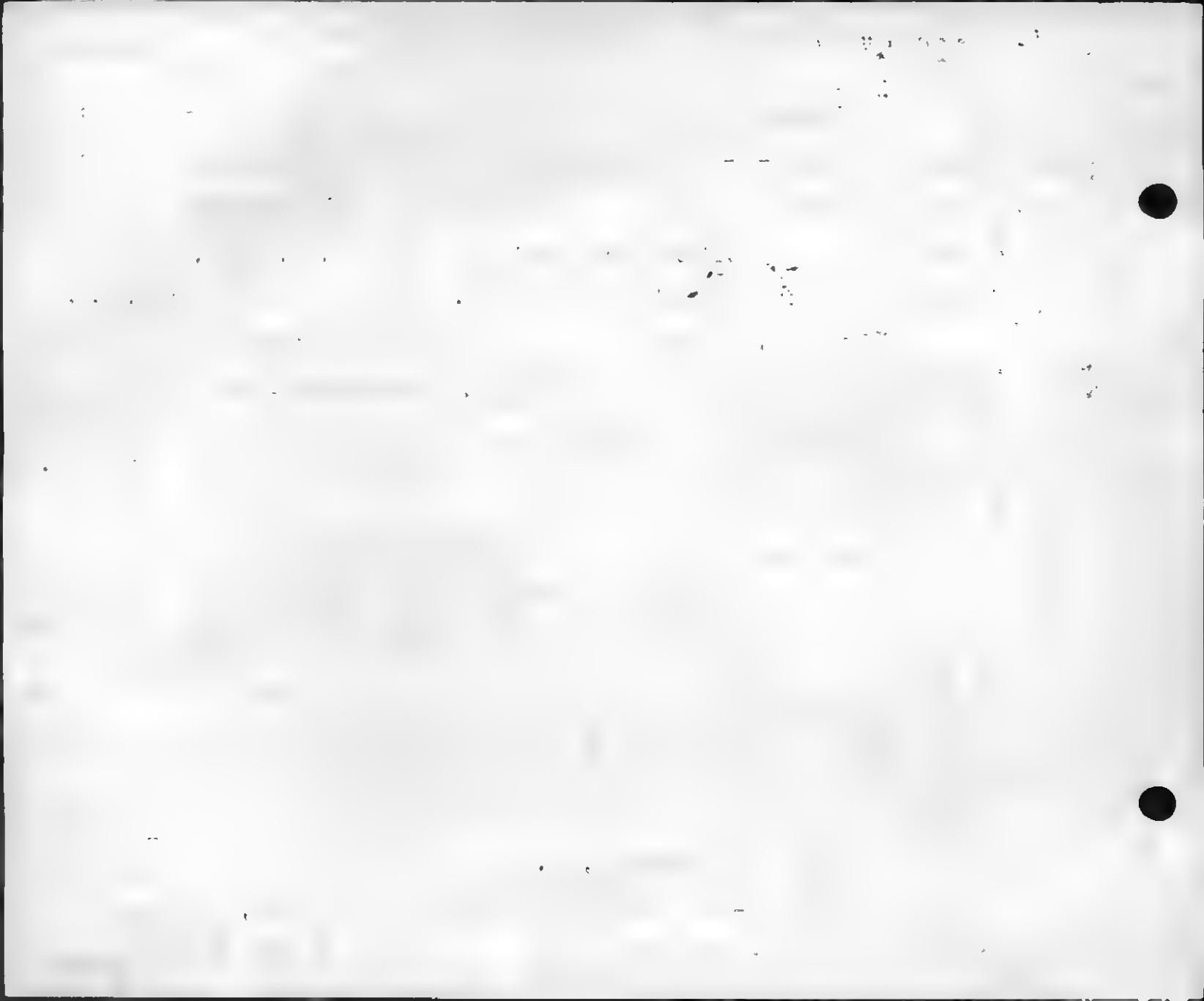


# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF EST- DEATH MATED <input checked="" type="checkbox"/> 10-10-68 12:55am M			2b HOUR
George			Stewart						
3. SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c DATE PRONOUNCED DEAD Month Day Year 10 10 68 19 3:15am M			2d HOUR
Male	White	1-16-1906	62 YRS						
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Washington DC		USA				Prince George's			Md
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY	
Cheverly		Prince George Hospital			Retd U. S. Govt.				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Maryland		Prince George's		Boulevard Hgts.				4916 Byers Street, S.E.	
14. FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
Albert E. Stewart			Catherine Nicholson						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS				
Yes WWII					Eva E. Stewart 4916-Byers St SE				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary hemorrhage DUE TO, OR AS A CONSEQUENCE OF Pulmonary tuberculosis (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours over 6 mo.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED	
EXAMINER'S NAME (Type)			John Kehoe MD Riverdale, Md.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		10-11-68	
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		
Burial			Oct 12-68		Cedar Hill Cemetery		Suitland, Maryland		
24 FUNERAL DIRECTOR			ADDRESS			25a. RECD BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Simmons Bros			Wash DC			OCT 14 1968		Charles Judge	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14957

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14967

1 DECEASED-NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 10-22-68 1910:10pm			2b HOUR
John Albert Stewart									
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		2c DATE PRONOUNCED DEAD Month 10 Day 22 Year 68 1910:48pm			2d HOUR
Male	White	12-27-1886	71 YRS						
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland.		USA				Prince George's			MD.
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY
Cheverly			Prince George Hospital						
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
Maryland			Prince George's Hillcrest Hgts.			2602 26th. Ave.			
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First Middle Last
Theodore Stewart						Mary Hayden			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown)			16b. SOCIAL SECURITY NO.			17 INFORMANT			ADDRESS
Yes			WW 1			Joseph A. Stewart-Mechanicsville, Md			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes unknown
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
4200									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
2a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			22b DATE SIGNED			
John Kehoe MD			Riverdale, Md.			10-23-68			
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		
Burial			Oct. 25, 68		Washington National Cem. Suitland, Maryland				
24 FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Simmons Bros.			Wash. DC.			OCT 25 1968		J. Charles Judge	





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

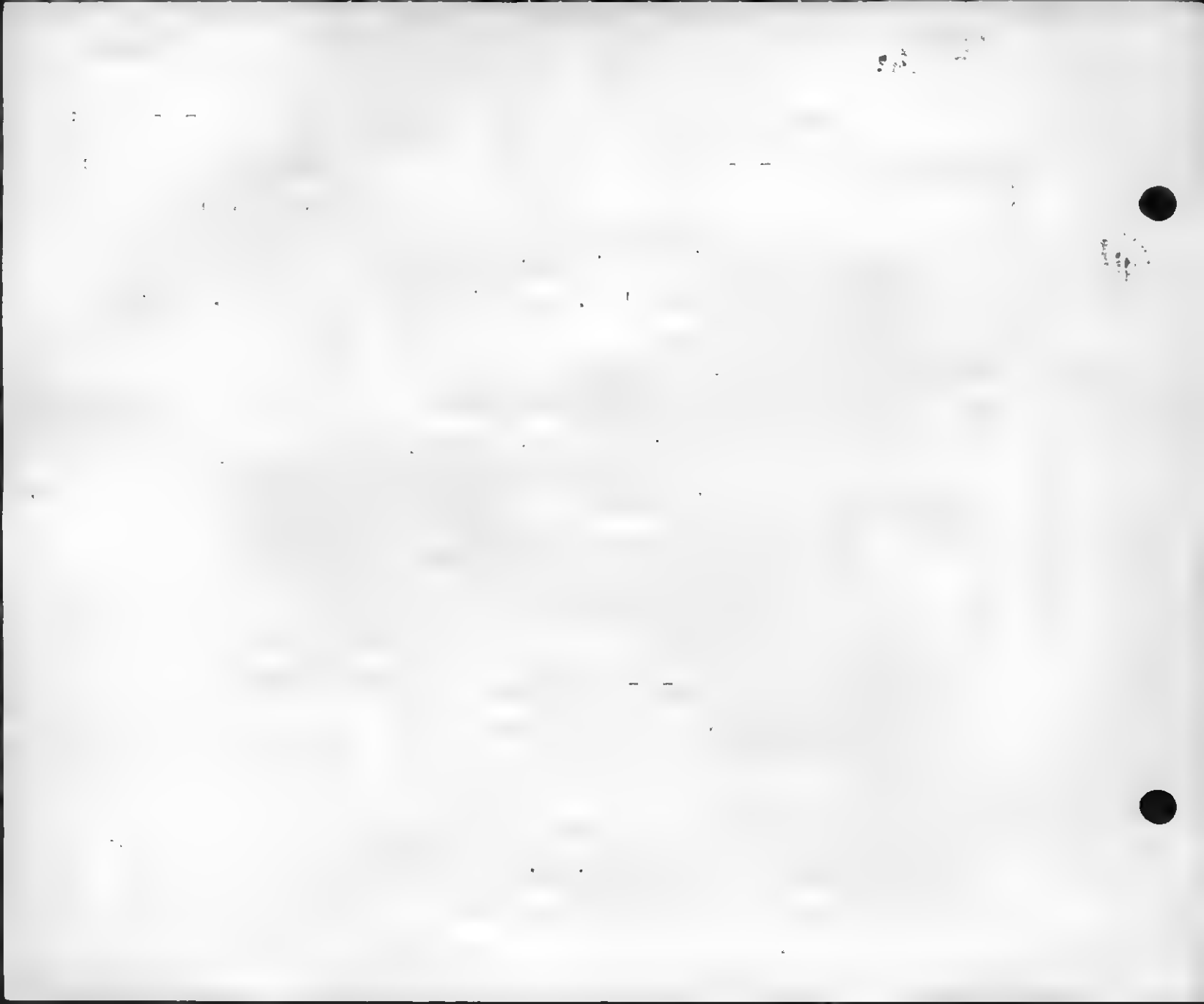
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14958

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14968

1. DECEASED NAME (Type or Print) <b>Carolyn</b>			First Middle Last <b>Strausbaugh</b>			2a. DATE KNOWN OF DEATH Month Day Year <b>10-28-68</b>			2b. HOUR 19 3:50pm				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>2-10-1940</b>		6. AGE (in years last birthday) <b>28</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD Month Day Year <b>10 28 68</b>			
7a. BIRTHPLACE (State or foreign country) <b>West Va</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Prince George's</b> Md.				
10. CITY OR TOWN OF DEATH <b>Cheverly</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince George Hospital</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) <b>Housewife</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
13a. USUA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>				13b. COUNTY <b>Prince George's</b>				13c. CITY OR TOWN <b>Hyattsville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>5903 37th. Avenue</b>	
14. FATHER'S NAME <b>Ernest Youngblood</b>				15. MOTHER'S MAIDEN NAME <b>Corinne Allen</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16b. SOCIAL SECURITY NO (If yes give war or dates of service) <b>219 36 8011</b>				17. INFORMANT <b>Richard S Strausbaugh</b> ADDRESS <b>West Hyattsville, Md</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive pulmonary embolus, acute</b> DUE TO, OR AS A CONSEQUENCE OF <b>Phlebo thrombosis lower extremity</b> (b) <b>From fracture of right tibia and fibula</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>over 2 mo.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a) <b>904.</b>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>8-28- 19 68</b>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Fell in back yard of home</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Back yard of home</b>				21f. LOCATION Street or R.F.D. No. City or Town County State <b>same as #13</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <b>John Kehoe MD</b>				EXAMINER'S NAME (Type) <b>John Kehoe MD Riverdale, Md.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town or county)				22b. DATE SIGNED <b>10-29-68</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE <b>Oct 31, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt Zion Church Cemetery</b>				23d. LOCATION (City or Town) (County) (State) <b>York Spring Garden Pa</b>			
24. FUNERAL DIRECTOR <b>F. Gasch's Sons, Hyattsville, Md.</b>				ADDRESS				25a. REC'D BY REGISTRAR DATE <b>NOV 1 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14959

14969

## CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month <u>15</u> , Day <u>1968</u> , Year		2b. HOUR <u>3:30 PM</u>	
Albert		Sturba						
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>Oct. 5, 1892</b>		6. AGE (In years last birthday) <b>76</b> YRS.		IF UNDER YEAR MONTHS <u>15</u> DAYS <u>15</u>
7a. BIRTHPLACE (State or foreign country) <b>ITALY</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George's</b> Md.		
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo. Gen'l Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>MACHINIST</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>GLASS. CO</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Prince George's</b>		13c. CITY OR TOWN <b>Bowie</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>12307 Firtree Lane</b>
14. FATHER'S NAME First Middle Last <b>RANIERO STURBA</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>CONSETTO FILARO</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <b>234 032446</b>		17. INFORMANT <b>RANIE J. STURBA</b>		Address <b>SAME AS #13</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gastrointestinal Hemorrhage;</b> DUE TO, OR AS A CONSEQUENCE OF <b>Acute multiple gastric ulcers; acute duodenal ulcer and hemorrhagic esophagitis.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>57C</b>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) <del>(the doctor)</del> attended the deceased from <u>Oct. 15, 1968</u> to <u>Oct. 15, 1968</u> , that (I) <del>(we)</del> lost saw the deceased alive on <u>Oct. 15, 1968</u> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death.								
22b. SIGNATURE <b>Barry Rosenberg M.D.</b>		22c. DATE SIGNED		22d. ADDRESS <b>6501 Landover Road, Cheverly, Md. 20785</b>		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
22d. PHYSICIAN'S NAME (Type) <b>BARRY ROSENBERG</b>		22e. ADDRESS <b>6501 Landover Road, Cheverly, Md. 20785</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>10-18-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN CEM</b>		23d. LOCATION (City or Town) (County) (State) <b>WHEATON, MARYLAND.</b>		
24. FUNERAL DIRECTOR <b>W.W. CHAMBERS CO RIVERDALE, MARYLAND</b>		24a. RECORD BY REGISTRAR <b>OCT 23 1968</b>		24b. REGISTRAR'S SIGNATURE <i>William J. Judge</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the pages. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1000

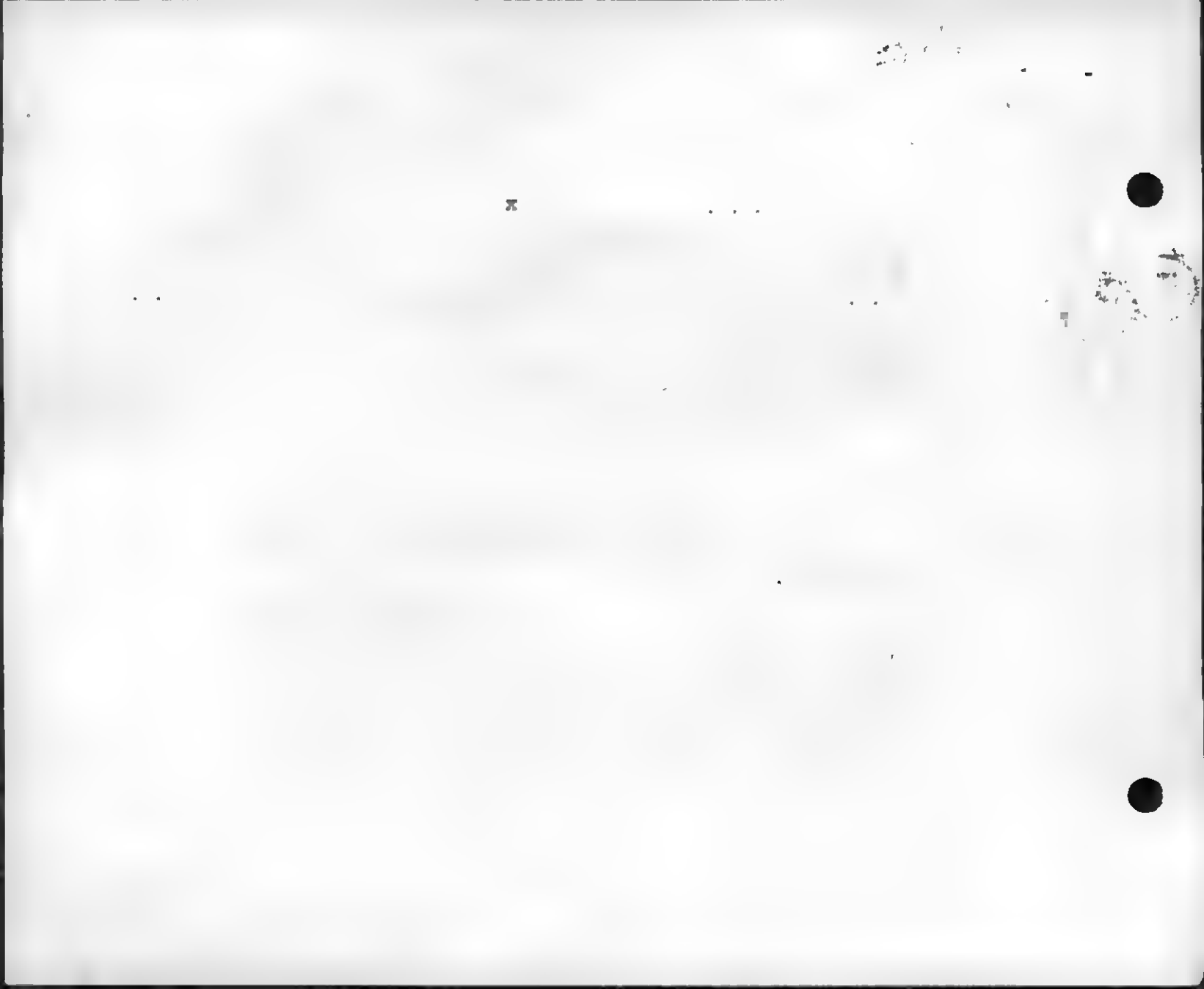
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 110  
30M REV 1-68

14960										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										14970									
1. DECEASED-NAME (Type or print)					First Middle Last					2a. DATE OF DEATH					2b. HOUR														
Annie					Sullivan					October					Day 11, Year 1968					9:10 A.M.									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			7. IF UNDER 1 YEAR			7. IF UNDER 24 HRS.														
Female			Negro			12-1-1889			78 YRS			MONTHS			DAYS														
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH																				
Virginia			U.S.A.						Prince Georges Md.																				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY																				
Glenn Dale			Glenn Dale Hospital			Unknown - Retired			----																				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER																	
D.C.			Washington			203 N Street S.W.																							
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME					16. SOCIAL SECURITY NO.					17. INFORMANT														
First Middle Last					First Middle Last					579 66 4380					JESSIE WINGFIELD Address Decedent 2390 GLETHORPE ST. N.W. WASH DC														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown					16b. SOCIAL SECURITY NO.					17. INFORMANT					JESSIE WINGFIELD Address Decedent 2390 GLETHORPE ST. N.W. WASH DC														
No					579 66 4380					JESSIE WINGFIELD					Decedent 2390 GLETHORPE ST. N.W. WASH DC														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction (clinical)															minutes														
+109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last															years														
DUE TO, OR AS A CONSEQUENCE OF arteriosclerotic heart disease															years														
DUE TO, OR AS A CONSEQUENCE OF generalized arteriosclerosis															years														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
Hypertension.																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)					21f. LOCATION Street or R.F.D. No City or Town County State																			
22a. I certify that (X) (this hospital) attended the deceased from 5/1/1968, to 10/11/1968, that (X) (we) last saw the deceased alive on 10/11/1968, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE Moe Weiss										DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>					22c. DATE SIGNED 10/11/1968														
22d. PHYSICIAN'S NAME (Type) Moe Weiss, MD										22e. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland																			
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE 10-16-68					23c. NAME OF CEMETERY OR CREMATORY Harmon Mem Ph.					23d. LOCATION (City or Town) (County) (State) Sandover Md														
24. FUNERAL DIRECTOR W.W. Dember Co 1400 Chapin St. N.W. Wash. D.C.										25a. REC'D BY REGISTRAR DATE OCT 16 1968					25b. REGISTRAR'S SIGNATURE J. Charles Judge														

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
45M - 1, 1969

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Gertrude V. Sullivan						Oct. 28, 1968			8:05 PM
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		7. UNDER 24 HRS
Female		Caucasian		6/19/93			75 YRS		MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
NEW YORK		U.S.					Prince George's Md		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Cheverly			Prince Geo. Gen'l Hospital			HOUSEWIFE			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INS OF CITY, LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
Maryland			Prince George's			Greenbelt			13e. STREET AND NUMBER
						6 Woodland Way			
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last					
WILLIAM J. NEILL				MARGARET MONAGHAN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO.		17. INFORMANT Address			
NO				094 32 4850		MRS HELEN G. PETERSON, SAME AS # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4109									3 weeks
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last									
(b) 4109									3 weeks
DUE TO, OR AS A CONSEQUENCE OF									
(c) Anterovascular heart disease									5 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
4201									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (the doctor) attended the deceased from October 5, 1968, to Oct. 28, 1968, that (I) (the doctor) last saw the deceased alive on Oct. 28, 1968, and that in (my) (your) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Hans Wodak						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 10-29-1968	
22d. PHYSICIAN'S NAME (Type) Hans Wodak, M. D.						22e. ADDRESS Professional Bldg, Greenbelt, Md. 20770			
23a. BURIAL CREMATION REMOVAL (Specify)			23b. DATE Nov-2, 1968		23c. NAME OF CEMETERY OR CREMATORY St. Raymond Cemetery		23d. LOCATION (City or Town) (County) (State) BRONX, NEW YORK, N.Y.		
24. FUNERAL DIRECTOR W.W. CHAMBERS & RIVERDALE, MARYLAND						25a. REC'D BY REGISTRAR DATE NOV 4 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

MEDICAL CERTIFICATION

1917

10000

10000

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

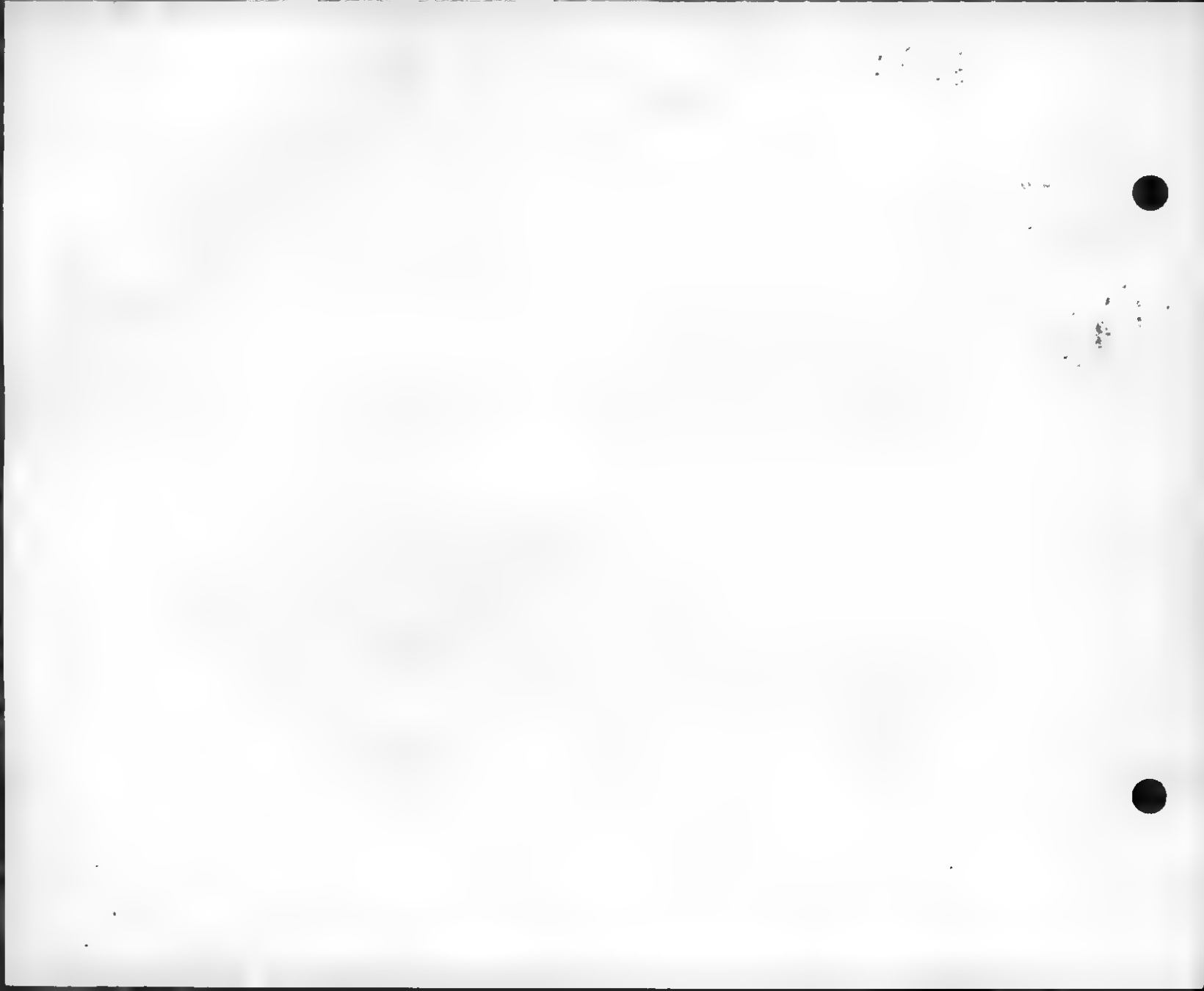
14962

**CERTIFICATE OF DEATH**

14972

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) <b>Edgar J. Swisher</b>			2a. DATE OF DEATH Month <b>10</b> Day <b>16</b> Year <b>68</b>			2b. HOUR <b>7:15</b> AM					
3 SEX <b>Male</b>		4 RACE <b>White</b>		5. DATE OF BIRTH <b>January 18, 1905</b>		6. AGE (In years last birthday) <b>63</b> YRS		7. UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN <b>0</b>			
7a. BIRTHPLACE (State or foreign country) <b>Kentucky</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U S</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George's</b> Md.					
10. CITY OR TOWN OF DEATH <b>Cheverly</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince George's Gen'l Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>D C</b>			13c. CITY OR TOWN <b>Greenbelt</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>38 East Ridge Road</b>	
14. FATHER'S NAME First <b>Edgar J.</b> Middle <b>Swisher</b> Last <b>Swisher</b>				15. MOTHER'S MAIDEN NAME First <b>Sally</b> Middle <b>Roberts</b> Last <b>Roberts</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>578 30 3472</b>			17. INFORMANT <b>Margaret K Swisher</b>			Address <b>Greenbelt, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary Embolism</b> <b>450 X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>None</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year <b>19</b> P.M. _____			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No _____ City or Town _____ County _____ State _____					
22a. I certify that (I) (this hospital) attended the deceased from <b>10-16</b> , 19 <b>68</b> , to <b>10-16</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>10-16</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>William C. Weintraub</b> M.D. PHYSICIAN'S NAME (Type)						22c. DATE SIGNED <b>OCT 21 1968</b>		22d. ADDRESS <b>Professional, Bldg. Greenbelt, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>Oct 19, 1968</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Suitland Pro Geo Md.</b>		
24. FUNERAL DIRECTOR <b>F. Gasch's Sons Hyattsville, Md.</b>						25a. REC'D BY REGISTRAR <b>OCT 21 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			



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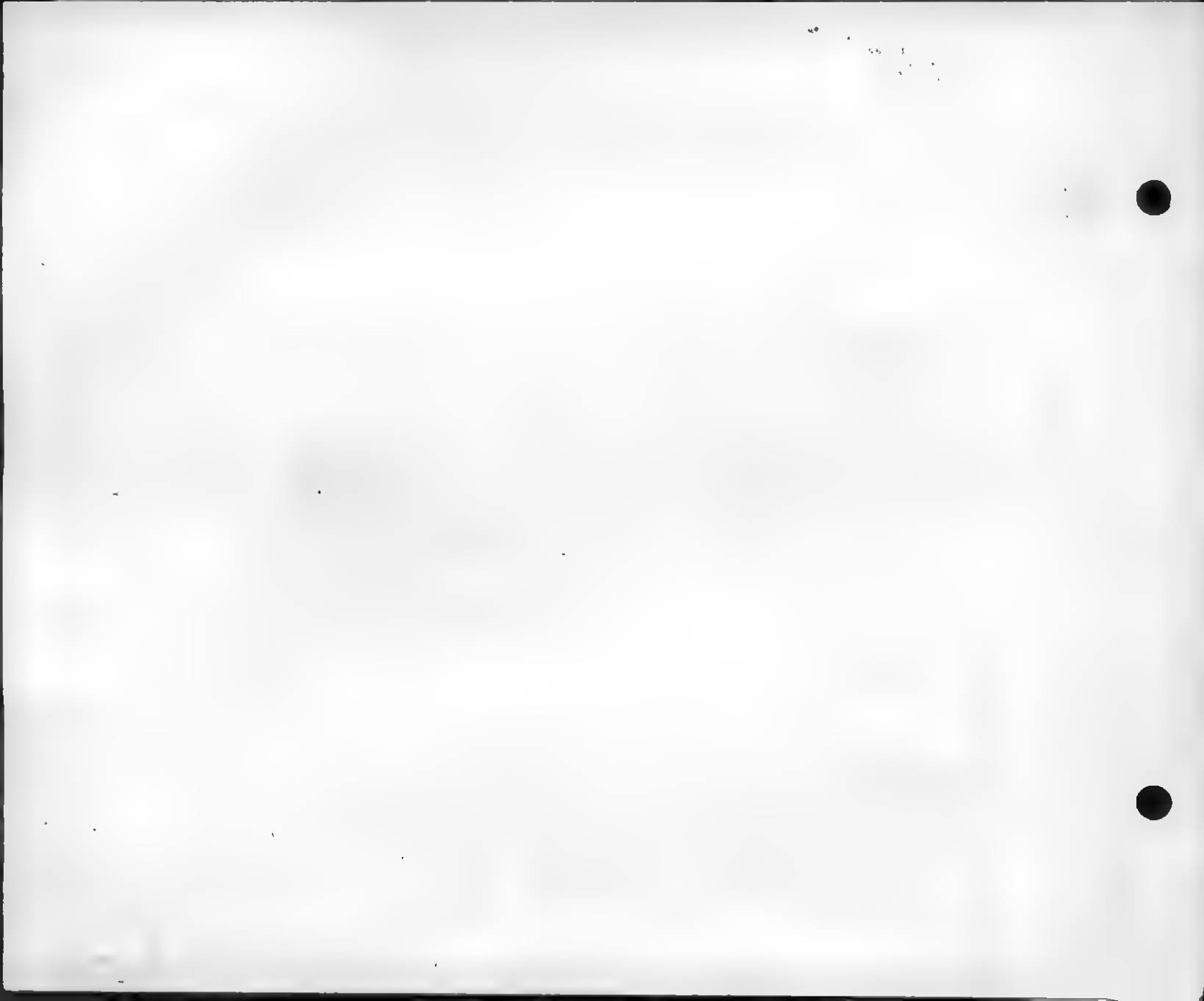
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14962

CERTIFICATE OF DEATH

14973

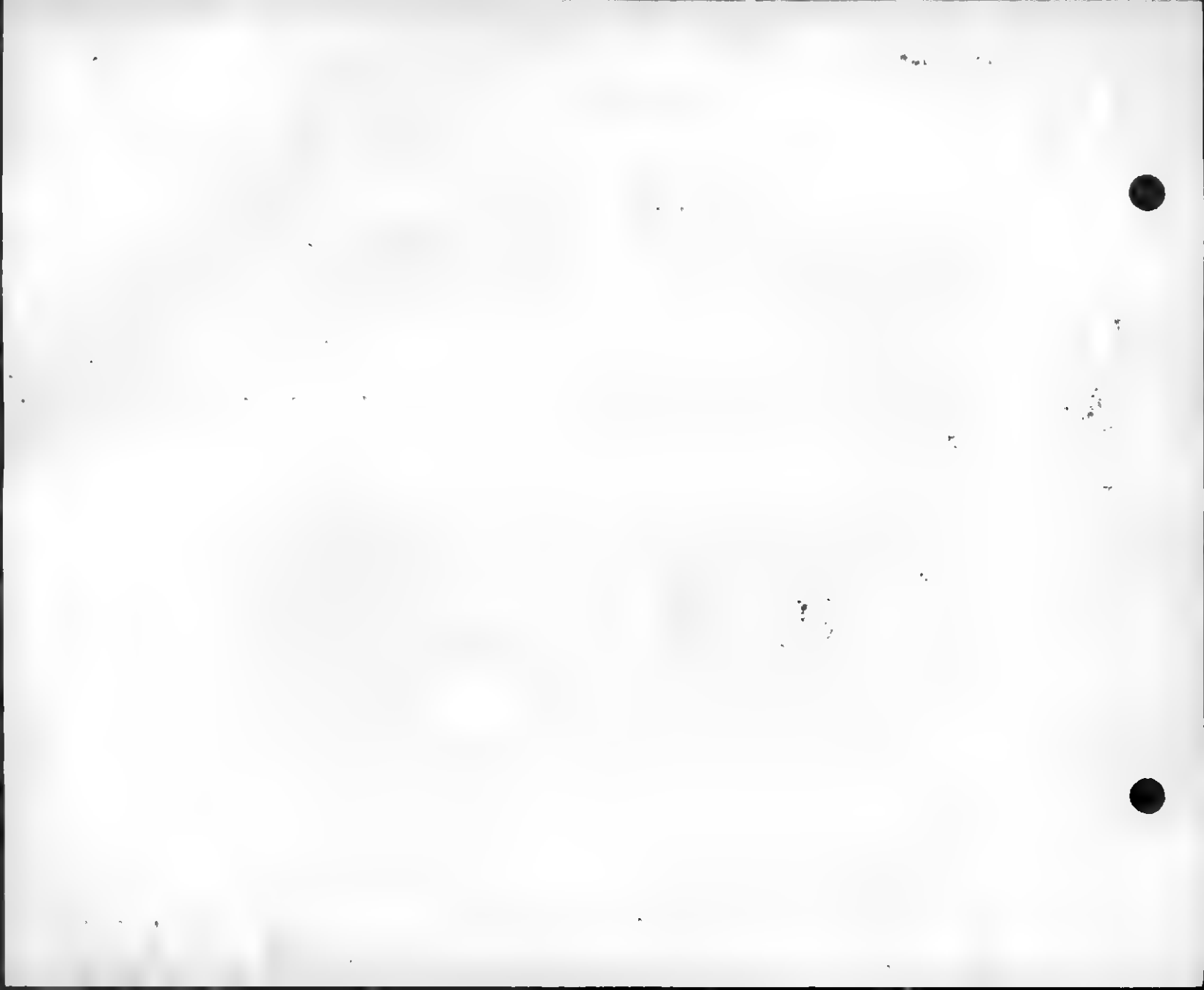
1 PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>—</u> COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FORESTVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON, D.C.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>REGENT REST HOME</u>		d. STREET ADDRESS <u>3235 O ST., S.E.</u>	
3 NAME OF DECEASED (Type or print) <u>Albert S. TAMORRIA</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>23</u> Year <u>1968</u>	
5 SEX <u>MALE</u>	6 COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>SEPT. 25, 1919</u>
9. AGE (In years last birthday) <u>49</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LOCKSMITH</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LOCKSMITH</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11 BIRTHPLACE (County & State, or foreign country) <u>WASH. D.C.</u>
13. FATHER'S NAME <u>IGNATIUS TAMORRIA</u>		14 MOTHER'S MAIDEN NAME <u>FRANCES C. AGATE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>579-10-2612</u>	17. INFORMANT <u>HOME RECORDS</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Broncho-Pneumonia Left Lung</u> 340X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Multiple Sclerosis</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>8 DAYS</u> <u>10 YRS.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>245V</u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (H) (this hospital) attended the deceased from <u>APR. 1</u> , 19 <u>66</u> , to <u>OCT. 23</u> , 19 <u>68</u> , that (H) (we) last saw the deceased alive on <u>OCT. 23</u> , 19 <u>68</u> , and that death occurred at <u>10:15 P.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>W. B. Sheer</u>		22b. DATE SIGNED <u>OCT. 23, 1968</u>	
22c. PHYSICIAN'S NAME (Type) <u>WALTER B. SHEER M.D.</u>		22d. ADDRESS <u>6400 MARLBORO PKE S.E. WASH. D.C. 20028</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>10/26/1968</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WASH. NATIONAL</u>	23d. LOCATION (City or town) (County) (State) <u>SUITLAND, M.D.</u>
24. FUNERAL DIRECTOR <u>JAMES T. RYAN, INC. 317 PA AVE S.E. WASH. D.C.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>OCT 28 1968</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
14966					14974								
1													
1. DECEASED NAME (Type or print)			First Gemma		Middle E milia		Last Tana		2a. DATE OF DEATH Month 6 Day 1968		2b. HOUR 4:45 M		
3. SEX female			4. RACE white		5. DATE OF BIRTH Nov. 30, 1892			6. AGE (In years last birthday) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Italy			7b. CITIZEN OF WHAT COUNTRY? <del>Italy</del> U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md.						
10. CITY OR TOWN OF DEATH Hyattsville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hyattsville Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Own Home				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.			13b. COUNTY P. G.		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY - MTS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2217 Beechwood Rd.				
14. FATHER'S NAME First Middle Last Dominic Barrecho					15. MOTHER'S MAIDEN NAME First Middle Last Pauline Barrecho								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. MA 517350		17. INFORMANT Mr. Francesco J. Tana, Sr.			Address Hyattsville, Md. 2217 Beechwood Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 7109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201 (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate undeterm.													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Cerebrovascular accident													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County State			
22a. I certify that (I) (this hospital) attended the deceased from 1950, 19 to Oct 6, 1968, that (I) (we) last saw the deceased alive on Oct 4, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE William F. Simpson MD						22c. DATE SIGNED 10/6/68		22d. PHYSICIAN'S NAME (Type) William F. Simpson MD					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 10-9-1968		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery			23d. LOCATION (City or Town) (County) (State) Washington, D. C.					
24. FUNERAL DIRECTOR Clark E. Wisor, Clark E. Wisor & Co., Inc., 8434 Georgia Avenue, N.W., Washington, D.C.						25a. REC'D BY REGISTRAR DATE OCT 10, 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 18 Form 406

11-13-68 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14965

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14975

1 DECEASED NAME (Type or Print) First Middle Last <b>Craig ALLEN Taylor</b>			2a DATE KNOWN OF DEATH Month Day Year <b>10-12-68 19 5:00am</b>		2b HOUR
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>9-27-1965</b>	6. AGE (in years last birthday) <b>3 YRS 14 MONTHS 14 DAYS</b>	2c DATE PRONOUNCED DEAD Month Day Year <b>10 12 68 19 7:45am</b>	
7a BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Prince George's Md.</b>
10 CITY OR TOWN OF DEATH <b>Cheverly</b>		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>Prince George Hospital</b>		12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired.) <b>None</b>	
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE <b>Maryland</b>		13b COUNTY <b>Prince George's</b>	13c CITY OR TOWN <b>Hyattsville</b>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER <b>6938 Decatur Place</b>
14. FATHER'S NAME First Middle Last <b>CHARLES W. TAYLOR</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>GLADYS HUSTON</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16b SOCIAL SECURITY NO. <b>NONE</b>		17 INFORMANT <b>CHARLES W. TAYLOR</b> ADDRESS <b>SAME AS #13</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Severe pulmonary edema and congestion</b> DUE TO, OR AS A CONSEQUENCE OF <b>Etiology undetermined</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>SDII</b> (b) <b>SDII</b> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION <b>7-7-68</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>John Kehoe MD</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASS STANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)		22b DATE SIGNED <b>10-13-68</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		23b DATE <b>10-15-1968</b>		23c NAME OF CEMETERY OR CREMATORY <b>FORT LINCOLN CEM</b>	
24 FUNERAL DIRECTOR <b>W.W. CHAMBERS Co. RIVERDALE, MD</b>		ADDRESS		25a REC'D BY REGISTRAR <b>OCT 16 1968</b>	
				25b REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	





# FOR STATE HEALTH DEPT.

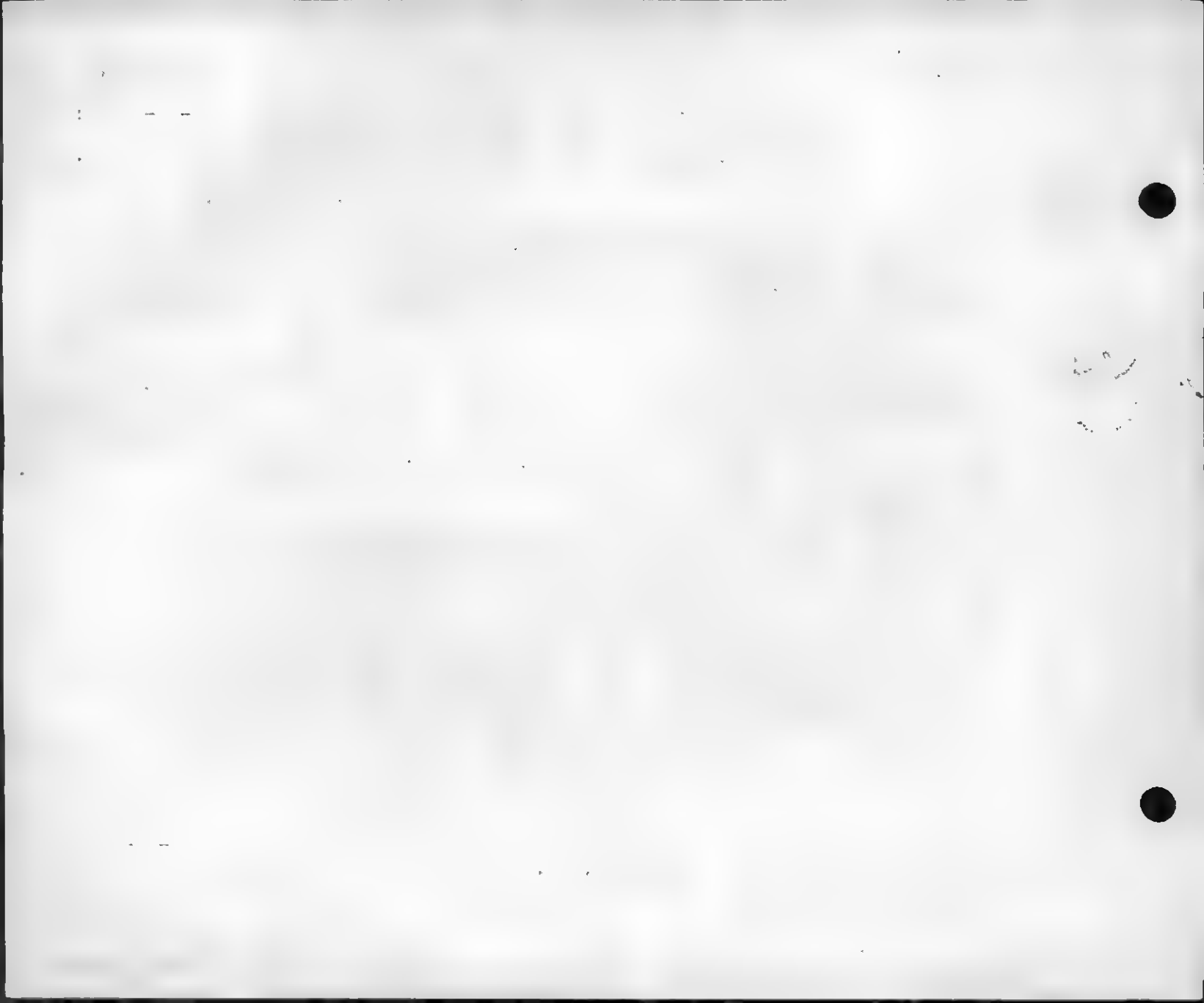
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (9)  
TOM REV 1-68

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF DEATH		Month	Day	Year	2b HOUR
Howard James Thomas					10-11-68		10	11	68	19:25pm
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD		Month	Day	Year
Male	White	4-20-1919	49 YRS			10-11-68		10	11	68
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
	USA				Prince George's		Md.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY			
Cheverly		Prince George Hospital			Painter		self employed			
13a USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) - STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER		
Maryland		Prince George's		Landover		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6726 Eldridge Street		
14 FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last	
Lester Thomas					Henrietta					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS				
yes		457 05 0528		Janet A Thomas		Landover, Md.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u>										minutes
DUE TO, OR AS A CONSEQUENCE OF <u>Arteriosclerotic heart disease</u>										over 2 yrs.
(b) _____ DUE TO, OR AS A CONSEQUENCE OF _____										
(c) _____ DUE TO, OR AS A CONSEQUENCE OF _____										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
4-2										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?				
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
CAUSE OF DEATH		19 P.M.								
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No.		City or Town		County		State
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED		
<i>John Kehoe</i>		John Kehoe MD Riverdale, Md.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		10-11-68		
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)		
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)
Burial		10/14/68		Ft Lincoln Cemetery		Colmar Manor Pro Geo				Md.
24 FUNERAL DIRECTOR		ADDRESS				25a REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
F. Gasch's Sons		Hyattsville, Md.				OCT 14 1968		<i>Charles Judge</i>		

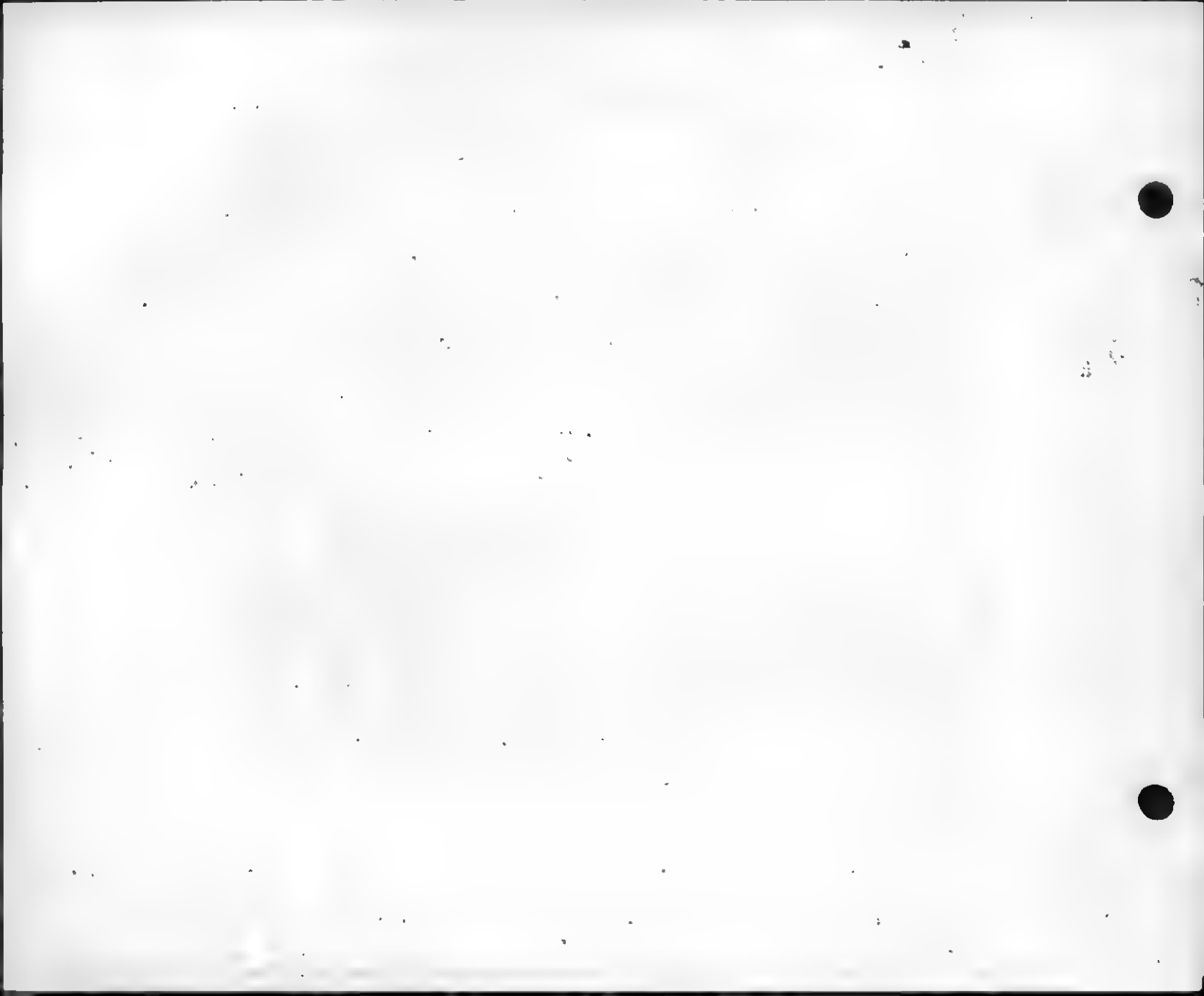


**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

VR A15 (4)  
30M REV 1/68

<div style="display: flex; justify-content: space-between;"> <span>14967</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH</span> <span>14977</span> </div> <div style="text-align: center;">             DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  <b>CERTIFICATE OF DEATH</b> </div>									
1. DECEASED-NAME (Type or print) First: William Middle: Henry Last: Thomas				2a. DATE OF DEATH Month: October Day: 28 Year: 1968				2b. HOUR 6:35 PM	
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH 11-6-72		6. AGE (In years last birthday) 95 YRS		IF UNDER 1 YEAR MONTHS: DAYS: HOURS: MIN:	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md			
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Eugene Leland Memorial Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Post Office Worker		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md.		13b. COUNTY Prince Georges		13c. CITY OR TOWN Brentwood		3a. INS DE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3911 Wallace Rd.	
14. FATHER'S NAME First: Harry Middle: Thomas Last: Thomas				15. MOTHER'S MAIDEN NAME First: Hannah Middle: Barns Last: Barns					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT Medical Record		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week undetermined	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from July 11, 1968, to Oct 28, 1968, that (I) (we) last saw the deceased alive on Oct 28, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE L. W. Malin MD				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 10-28-68			
22d. PHYSICIAN'S NAME (Type) L. W. Malin, M. D.				22e. ADDRESS 4400 Queensbury Road, Riverdale, Md. 20840					
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE 11-1-68		23c. NAME OF CEMETERY OR CREMATORY Shiloh Methodist Ch. Cemetery		23d. LOCATION (City or Town) (County) (State) Newburg, Maryland			
24. FUNERAL DIRECTOR Rhines Company Funeral Home 3015 12th Street, N. E.				25a. REC'D BY REGISTRAR DATE NOV 1 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

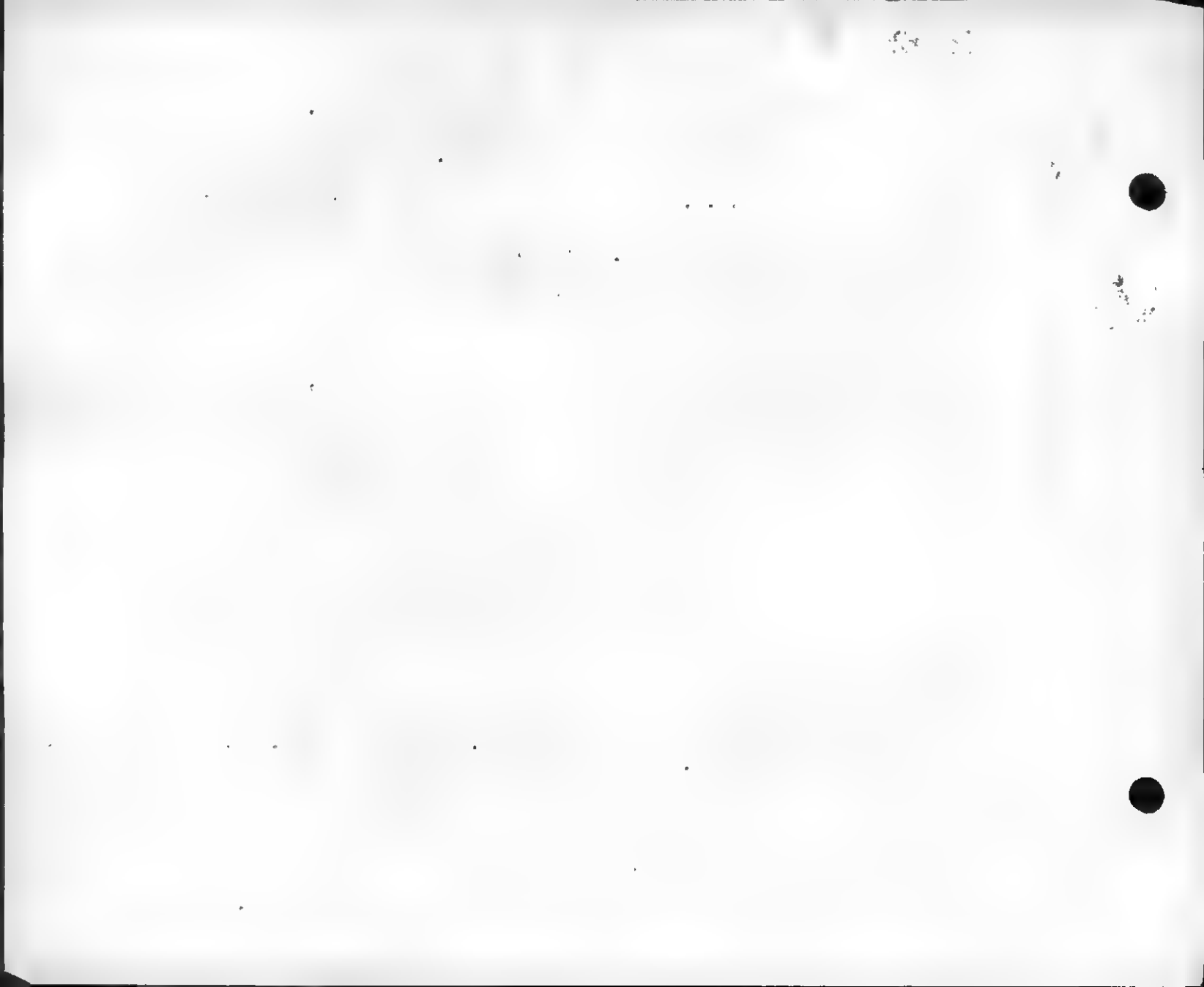
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14968

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

14978

1. DECEASED NAME (Type or print) <b>ANTHONY</b> <sup>First</sup> <b>WAYNE</b> <sup>Middle</sup> <b>Thompson</b> <sup>Last</sup>		2a. DATE OF DEATH Month <b>Oct.</b> Day <b>16</b> Year <b>1968</b>		2b. HOUR <b>3:30PM</b>	
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>Sept. 22, 1968</b>	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo. Gen'l Hospital</b>		9. COUNTY OF DEATH <b>Prince George's</b> Md.	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Prince George's</b>		13c. CITY OR TOWN <b>Suitland</b>	
14. FATHER'S NAME First Middle Last <b>Sidney Thompson</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Nancy Lee Norwood</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> or unknown <input type="checkbox"/> (If yes give war or dates of service)	
16b. SOC. SEC. NO. <b>NONE</b>		17. INFORMANT Address <b>Sidney C. Thompson, Same as #13 (Father)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Peritonitis due to spontaneous perforation of-</b> <b>Jejunum,</b> DUE TO, OR AS A CONSEQUENCE OF <b>a recurrence of intestinal obstruction.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Congenital Atresia of Ileum.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Congenital Gastroschisis.</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? Yes <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>Sept. 22, 1968</b> , to <b>Oct. 16, 1968</b> , that (I) <del>(xxx)</del> last saw the deceased alive on <b>Oct. 16, 1968</b> , and that in (my) <del>(xxx)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(xxx)</del> (did) <del>(xxx)</del> view the body after death.					
22b. SIGNATURE <b>R. Longoria M.D.</b>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) <b>Ricardo Longoria M.D.</b>		22e. ADDRESS <b>6001 Landover Road, Cheverly, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>10-18-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	
23d. LOCATION (City or Town) (County) (State) <b>Suitland, Maryland</b>		23e. LOCATION (City or Town) (County) (State) <b>Suitland, Maryland</b>			
24. FUNERAL DIRECTOR <b>Wilhelm Funeral Home</b> ADDRESS <b>4308 Suitland Rd. Suitland, Maryland</b>				25a. REC'D. BY REGISTRAR <b>Oct 23 1968</b> DATE	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>				25c. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14969

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

14979

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month <u>25</u> , Day <u>1968</u> Year		2b. HOUR <u>10:30</u> AM		
Ruth		T.	Traicoff		Oct.				
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Female	Caucasian		Oct. 1, 1912		58 YRS.		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md		
Kentucky	U.S.A.				Prince George's				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Cheverly		Prince Geo.Gen'l Hospital		Housewife		HOME			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Prince George's		Dist.Hgts.				7903 Foster St.	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
David		Winsted			Mabel				Riley
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No		UNKNOWN		Dimitri Traicoff - same as above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC AND RESPIRATORY ARREST.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic carcinoma to lungs and pericardium</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma Right breast - (Radical mastectomy 8 yrs ago)</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (this hospital) attended the deceased from <u>Oct. 18, 1968</u> to <u>Oct. 25, 1968</u> , that <u>we</u> last saw the deceased alive on <u>Oct. 25, 1968</u> , and that in <u>our</u> (our) opinion death occurred on the date and hour and from the causes stated above, <u>and we</u> (did) <u>not</u> view the body after death.									
22b. SIGNATURE <u>Luis F. Bentolila</u>				DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>10-25-68.</u>			
22d. PHYSICIAN'S NAME (Type) Luis F. Bentolila, M. D.				22e. ADDRESS Prince Geo.Gen'l Hospital, Cheverly, Md.					
23a. BURIAL, CREMATION (Type)		23b. DATE <u>10-28-68</u>		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		23d. LOCATION (City or Town) (County) (State) SUITLAND, MARYLAND			
24. FUNERAL DIRECTOR Wilhelm Funeral Home 4308 Suitland Rd., Suitland, Maryland				25a. REC'D BY REGISTRAR DATE <u>NOV 1 1968</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14970

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items #7a, b Film 340

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14980

1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF EST DEATH MATED			Month Day Year			2b HOUR 19																									
Bernard			G			Tydings			10-9-68			4:00pm																									
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years as birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD		2d HOUR																							
Male		White		7-30-1915		53 YRS						10 9 68		4:30pm																							
7a BIRTHPLACE (State or foreign country)				7b CITIZEN OF WHAT COUNTRY?				8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9 COUNTY OF DEATH																									
Maryland				USA								Prince George's Md																									
10 CITY OR TOWN OF DEATH						11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)						12b KIND OF BUSINESS OR INDUSTRY																			
Bladensburg						5350 Quincy Place						Trainman Washington Terminal																									
13a USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) STATE						13b COUNTY						13c CITY OR TOWN						13d HOUSE CITY, STATE						13e STREET AND NUMBER													
Maryland						Prince George's						Bladensburg						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						5350 Quincy Place													
14 FATHER'S NAME						15 MOTHER'S MAIDEN NAME						16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16b SOCIAL SECURITY NO (If yes give war or dates of service)						17 INFORMANT						ADDRESS							
Clement Tydings						Florence Butler						no												Mrs Marian E Tydings						Bladensburg, Md.							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART I. DEATH WAS CAUSED BY:																																					
IMMEDIATE CAUSE (a)																		Gun shot wound of head																			
955X																																					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																																					
DUE TO, OR AS A CONSEQUENCE OF																																					
(b)																																					
DUE TO, OR AS A CONSEQUENCE OF																																					
(c)																																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																																					
4167																																					
19a DATE OF OPERATION												19b CONDITION FOR WHICH OPERATION WAS PERFORMED?												20 AUTOPSY?													
																								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>												21b. TIME OF INJURY Month, Day, Year HOUR A.M.												21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)													
CAUSE OF DEATH												11:00am 10-9-1968												Shot self at home													
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK												21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)												21f LOCATION Street or R.F.D. No City or Town County State													
												Home												Same as #13													
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																																					
ACTUAL SIGNATURE												CHIEF MEDICAL EXAMINER <input type="checkbox"/>												22b. DATE SIGNED													
EXAMINER'S NAME (Type)												ASS STANT MEDICAL EXAMINER <input type="checkbox"/>												10-10-68													
John Kehoe MD												Rivendale, Md.																									
23a BURIAL, CREMATION, REMOVAL (Specify)												23b DATE												23c. NAME OF CEMETERY OR CREMATORY												23d LOCATION (City or Town) (County) (State)	
Burial												Oct 12, 1968												Ft Lincoln Cemetery												Colmar Manor, Pro Geo Md.	
24 FUNERAL DIRECTOR												ADDRESS												25a REC'D BY REGISTRAR												25b REGISTRAR'S SIGNATURE	
F. Gasch's Sons												Hyattsville, Md.												OCT 14 1968												J Charles Judge	

-- I :

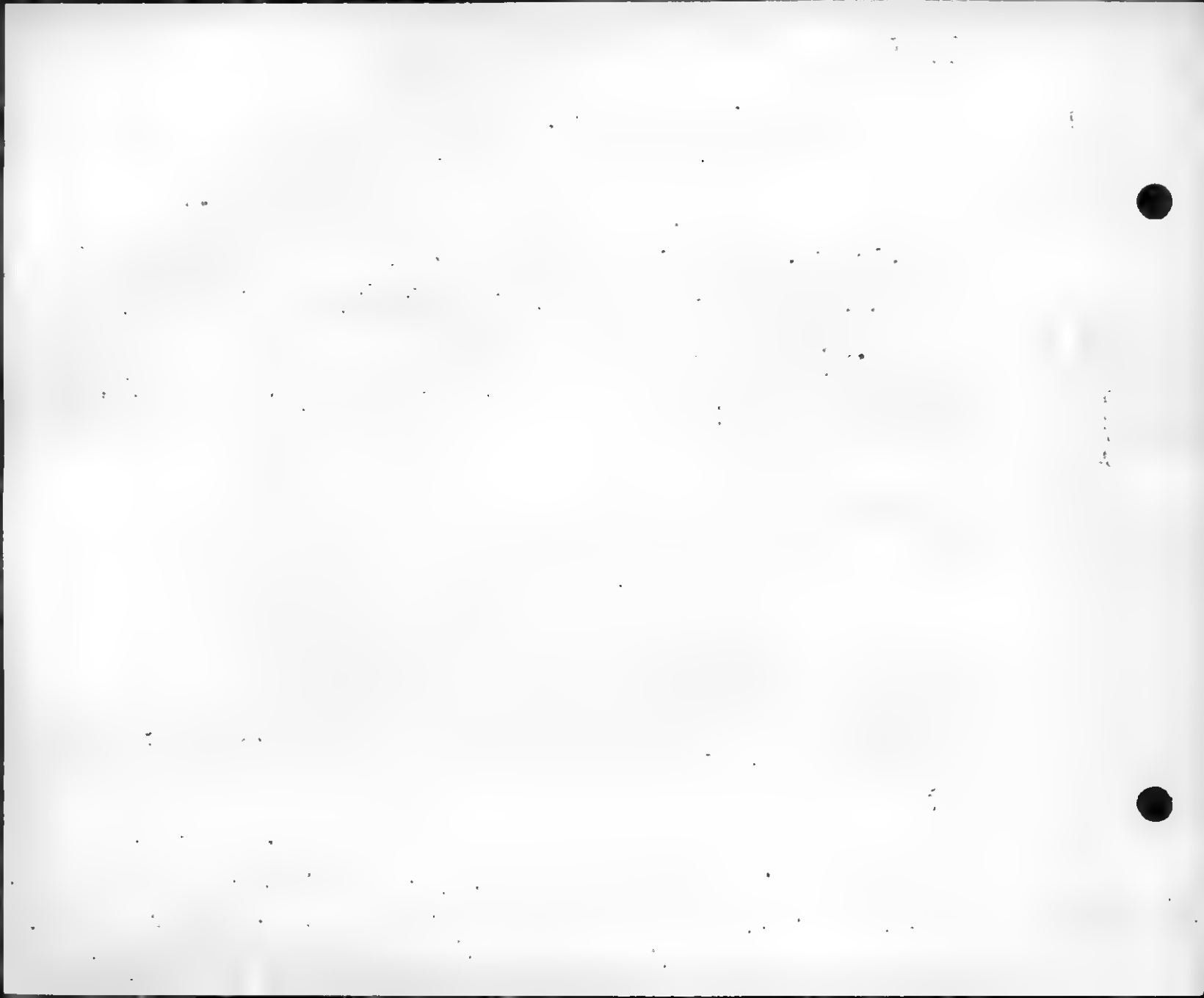
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
304 REV 1-65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print) <del>First</del> Hazel I. <del>Middle</del> <del>Last</del> TYLER			2a DATE OF DEATH Month 10- Day 23 Year 68			2b HOUR 4:15 PM					
3 SEX Female			4 RACE White			5 DATE OF BIRTH 7-1-98			6 AGE (In years last birthday) 70 YRS.		
7a BIRTHPLACE (State or foreign country) Md.			7b CITIZEN OF WHAT COUNTRY? US			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. COUNTY OF DEATH Prince Georges Md		
10. CITY OR TOWN OF DEATH Riverdale, Md.			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Leland Memorial Hosp.			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE			12b KIND OF BUSINESS OR INDUSTRY HOME		
13a USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Md.			13b COUNTY Howard			13c CITY OR TOWN Laurel			13d INSIDE CITY LIMITS? NO		
13e STREET AND NUMBER Rt #5			14. FATHER'S NAME First Middle Last WILLIE W Wastler			15. MOTHER'S MAIDEN NAME First Middle Last Helen Wills					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) no			16b SOCIAL SECURITY NO.			17 INFORMANT EDNA PUNCKE LAUREL MD			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Heart Disease - War Hypertension</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1965, 19, to 1968, 25, that (I) (we) lost saw the deceased alive and 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE Robert C. Wingfield						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c DATE SIGNED 10-25-68		
22d. PHYSICIAN'S NAME (Type) ROBERT C WINGFIELD						22e. ADDRESS Laurel, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 10-26-68			23c. NAME OF CEMETERY OR CREMATORY PLEASANT HILL			23d. LOCATION (City or Town) (County) (State) YELLOW SPRINGS MD		
24. FUNERAL DIRECTOR Donaldson Funeral Home, Laurel						ADDRESS			25a REC'D BY REGISTRAR DATE OCT 28 1968		
						25b. REGISTRAR'S SIGNATURE Charles Judge					

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
304 REV 11-68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
14972		CERTIFICATE OF DEATH				14982			
1 DECEASED-NAME (Type or print) <b>Annie Wade</b>			First Middle Last			2a. DATE OF DEATH Month <b>Oct.</b> Day <b>13</b> Year <b>68</b>			2b. HOUR <b>12,55A</b>
3 SEX <b>Female</b>		4. RACE <b>White</b>		5 DATE OF BIRTH <b>14 Nov., 1904</b>			6 AGE (In years last birthday) <b>63</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS M.N.
7a. BIRTHPLACE (State or foreign country) <b>England</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH <b>Pr. Geo.,</b> Md		
10. CITY OR TOWN OF DEATH <b>Cheverly</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Pr. Geo., Gen. Hosp.,</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Pr. Geo.,</b>		13c. CITY OR TOWN <b>Greenbelt</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>15 B Ridge Rd.</b>
14. FATHER'S NAME First <b>Andrew</b> Middle <b>Hinchliffe</b> Last <b>Any</b>			15. MOTHER'S MAIDEN NAME First <b>Any</b> Middle <b>Rhodes</b> Last <b>Rhodes</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>119 26 3976</b>		17 INFORMANT <b>Willie Wade</b>		Address <b>Same as 13</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Metastatic Leukemia</b> <b>17 + x</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Adenocarcinoma of Rt breast</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>1 year</b>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept</b> , 1967, to <b>Oct 13</b> , 1968, that (I) (we) last saw the deceased alive on <b>Oct 13</b> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>William C. Weintraub, MD</b>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) <b>William C. Weintraub</b>						22e. ADDRESS <b>Greenbelt ProfslBg Greenbelt Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10/16/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor Pr. Geo. Md.</b>			
24. FUNERAL DIRECTOR <b>F. Gasch's Sons Hyattsville, Maryland</b>						25a. REC'D BY REGISTRAR DATE <b>OCT 16 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

MEDICAL CERTIFICATION



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Item 23a Film G406 11/7/68 k  
14973

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

14983

1. DECEASED NAME (Type or print)		First <b>James</b>	Middle <b>--</b>	Last <b>Waiters</b>	2a. DATE OF DEATH Month <b>10</b> Day <b>27</b> Year <b>68</b>		2b. HOUR <b>5:50</b> <sup>A</sup> <sub>M</sub>				
3. SEX <b>Male</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH <b>1/22/1923</b>		6. AGE (In years - last birthday) <b>45</b> YRS		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS HOURS <b>0</b> MIN <b>0</b>	
7a. BIRTHPLACE (State or foreign country) <b>S. C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince Georges</b> Md					
10. CITY OR TOWN OF DEATH <b>Glenn Dale</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Glenn Dale Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>unknown</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>unknown</b>		13b. COUNTY <b>Wash., D.C.</b>		13c. CITY OR TOWN <b>Wash., D.C.</b>		13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13e. STREET AND NUMBER <b>644 Columbia Rd., N. W.</b>			
14. FATHER'S NAME First <b>Unknown</b> Middle <b>Unknown</b> Last <b>Unknown</b>				15. MOTHER'S MAIDEN NAME First <b>Unknown</b> Middle <b>Unknown</b> Last <b>Unknown</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16b. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>D.C. General Hospital Records</b>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bronchogenic carcinoma, left lung, with metastasis (autopsy finding)</b> <b>1621</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>1621</b> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <b>Left cerebral infarction, old, with right hemiplegia and aphasia; generalized arteriosclerosis</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR <b>19</b> A.M. Month <b>10</b> Day <b>27</b> Year <b>68</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that <del>the</del> (this hospital) attended the deceased from <b>3/20/</b> 19 <b>68</b> , to <b>10/27/</b> 19 <b>68</b> , that <del>the</del> (we) last saw the deceased alive on <b>10/27/</b> 19 <b>68</b> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>the</del> (we) (did) <del>not</del> view the body after death.											
22b. SIGNATURE <b>Moe Weiss</b>				DEGREE		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>10/27/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b>				22e. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>11/4/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Harmony Memorial Park</b>			23d. LOCATION (City or Town) (County) (State) <b>Maryland</b>				
24. FUNERAL DIRECTOR <b>J. T. Stewart, Jr.</b>				ADDRESS <b>Home 4001 Benning Rd.</b>		25a. REC'D BY REGISTRAR <b>NOV 4 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			





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VR A15 (4)  
25M 1/67

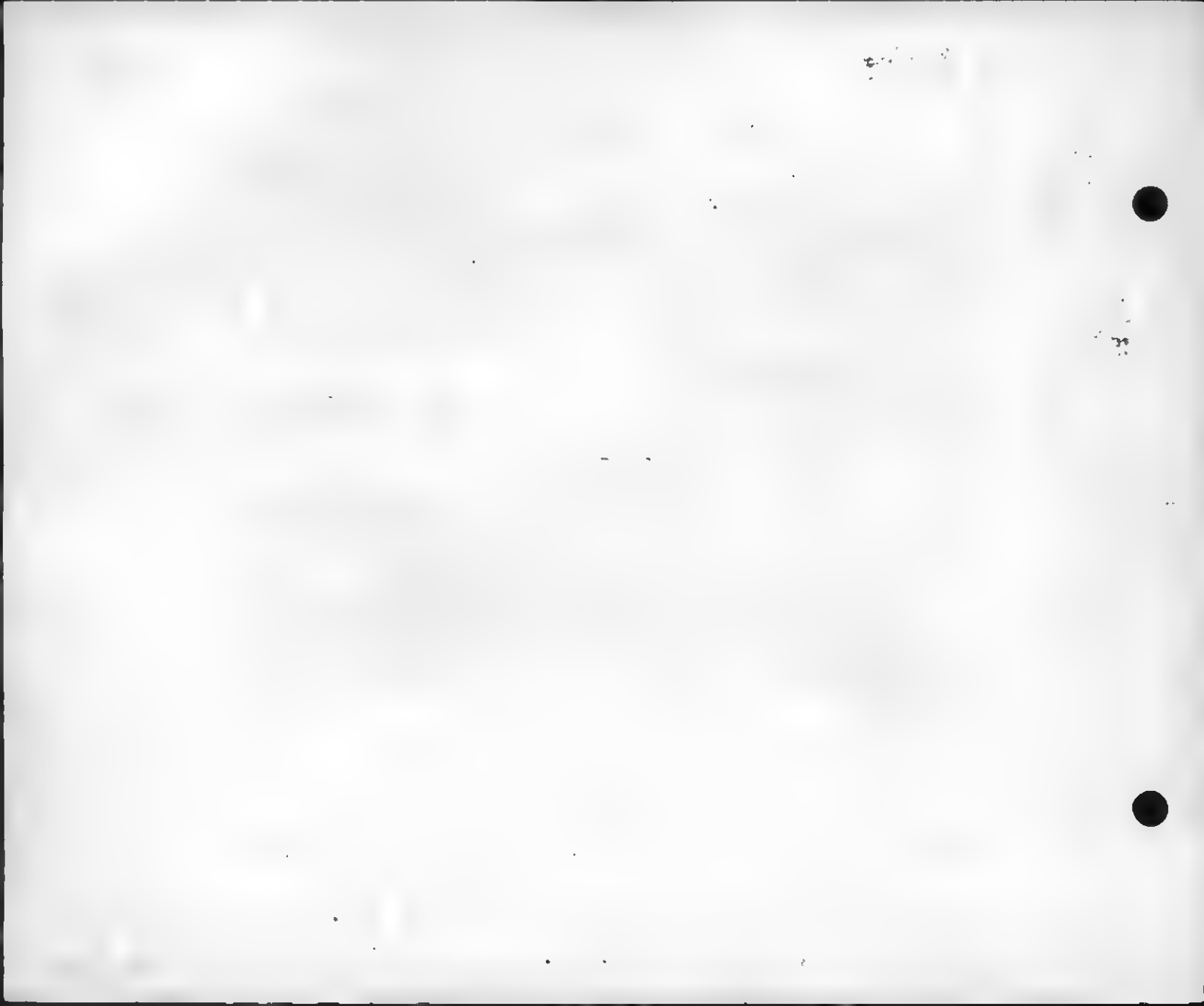
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14974

CERTIFICATE OF DEATH

14984

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>VIRGINIA</b> COUNTY <b>Fairfax</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AFB</b>		c. LENGTH OF STAY IN 1b <b>Fairfax 22030</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MALCOM GROW USAF HOSP</b>		d. STREET ADDRESS <b>9126 Glenbrook Road</b>	
3. NAME OF DECEASED (Type or print) <b>SARAH J WEST</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>20</b> Year <b>1968</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>CAU</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>27 Nov 1911</b>
9. AGE (In years last birthday) <b>56</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Business Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Samuel K. Webster</b>		14. MOTHER'S MAIDEN NAME <b>Ethel <del>Webster</del> Marie Hood</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>089-05-1554</b>	
17. INFORMANT <b>Frank T West</b>		Address <b>9126 Glenbrook Rd, Fairfax, Va.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from <b>22 July 1968</b> to <b>20 Oct 1968</b> that (I) (we) last saw the deceased alive on <b>20 Oct 1968</b> and that death occurred at <b>0600 AM</b> from causes and on the date stated above.			
22a. SIGNATURE <i>G. O. Hatzimihalis</i>		22b. DATE SIGNED <b>20 Oct 68</b>	
22c. PHYSICIAN'S NAME (Type) <b>G. O. HATZIMIHALIS, M.D.</b>		22d. ADDRESS <b>MALCOM GROW USAF HOSP. ANDREWS AFB, WASH D.C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>10/23/68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem., Arlington, Virginia</b>	
24. FUNERAL DIRECTOR <b>Falls Church, Falls Church, Va.</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 22 1968</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
14973					14985						
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print)			First Middle Last		2a DATE OF DEATH Month Day Year			2b HOUR P			
Mary Elizabeth E.			Wilding		October 29 1968			5:50 PM			
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
Female		White		May 8, 1889			79 YRS				
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
District of Columbia			United States				Prince George Md				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Hyattsville			Sacred Heart Home			Clerical			Government		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER				
Maryland			Prince George		Hyattsville		620 Sheridan St. Apt. 319				
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last								
William A. Wilding			Mary Frances O'Dea								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO		17 INFORMANT						
no			579-60-5108		Sacred Heart Home, 620 Sheridan St., Hyattsville, Maryland						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis										3 wks.	
4129 DUE TO, OR AS A CONSEQUENCE OF											
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last 4200										under.	
(b) Arteriosclerotic heart disease with											
DUE TO OR AS A CONSEQUENCE OF											
(c) auricular fibrillation											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
Parkinsonism, severe											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc)			21f LOCATION Street or R.F.D. No City or Town County State					
22a I certify that (I) (this hospital) attended the deceased from Feb 1952, to Oct 29 1968, that (I) (we) last saw the deceased alive on Oct 29 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE MD DEGREE <input checked="" type="checkbox"/> ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>										22c DATE SIGNED	
22d PHYSICIAN'S NAME (Type) William F. Simpson, MD										6216 N.H. Ave NE - DC 20011	
23a BURIAL CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)			
			11-2-1968		Mt. Olivet Cemetery			Washington, D.C.			
24 FUNERAL DIRECTOR John M. Poe ADDRESS 8134 Ga. Avenue										25a REC'D BY REGISTRAR	
25b REGISTRAR'S SIGNATURE										25c DATE	
25d NOV 7 1968										25e	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with your files. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14976 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										14986	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			2b HOUR		
David P Wilkins						Month Day Year			10-31-68 11:12pm		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD			2d HOUR
Male	White	2-4-1954	14 YRS	MONTHS	DA	HOURS	MIN	Month Day Year	10 31 68 11:30am		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			Md		
Mass.		U S A					Prince George's				
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Clinton			Clinton Medical Center			Student					
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS?		
Maryland			Prince George's			Cheltenham			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e STREET AND NUMBER					
First Middle Last			First Middle Last			Quarters B					
William R. Wilkins			Fern E. Stahl								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown)			16b SOCIAL SECURITY NO			17. INFORMANT			ADDRESS		
No			---			William R. Wilkins			Quarters B. Naval Con. Sta.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laceration of brain											
DUE TO, OR AS A CONSEQUENCE OF Trauma auto accident											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			11:00am 10-31-19 68			Passenger of car involved in collision.					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or RFD No City or Town County State					
			Rt. 5, 200 feet north of Rt. 381, T.B., Prince George Co., Md.								
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			ASSISTANT MEDICAL EXAMINER			22b DATE SIGNED		
EXAMINER'S NAME (Type)			ADDRESS			DEPUTY MEDICAL EXAMINER			11-1-68		
John Kehoe MD			Riverdale, Md.			<input checked="" type="checkbox"/>					
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)			
Cremation			11-4-68		Cedar Hill Cemetery			Suitland Pr. Geo. Md.			
24 FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE		
Wilhelm Funeral Home			4308 Suitland Rd. S. E.			NOV 6 1968			Charles Judge		



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 1b. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

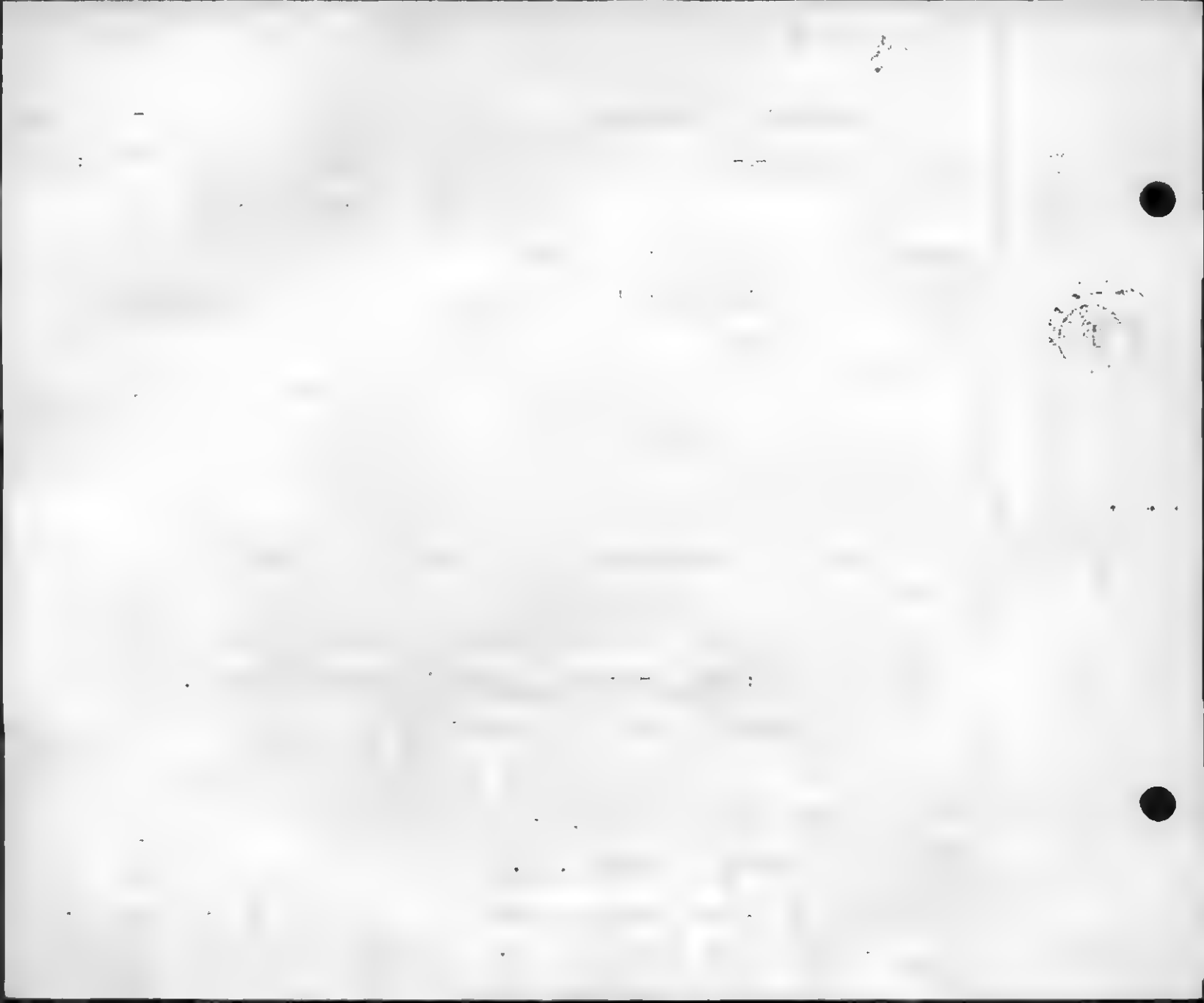
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14977

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14987

1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF EST. DEATH MATED				2b HOUR	
Frances Louise Wood						10-15-68 10:00am					
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD		2d HOUR	
Female	White	2-1-1915	53 YRS	MONTHS	DAYS	HOURS	MIN	10 15 68		12:30pm	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Texas		U S A		Prince George's Md.							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a USUA. OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Hyattsville			8303 Fremont Place			Housewife			Home		
13a. USUAL RES DENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Maryland			Prince George's			Hyattsville			YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e STREET AND NUMBER					
First Middle Last			First Middle Last			8303 Fremont Place					
Harold Smith			Willie V Vaughn								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17. INFORMANT			ADDRESS		
no			577 24 5263			Walter H Wood			Hyattsville, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Asphyxia</u> 153x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF <u>Hanging</u> (b) DUE TO, OR AS A CONSEQUENCE OF (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o)											
174x											
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY?		
									YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
2a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year HOUR A.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
CAUSE OF DEATH			10:00am 10-15-68			Hung self in basement of home.					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or RFD No.			City or Town County State		
			Basement of home			same as #13					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED		
<i>John Kehoe</i>			John Kehoe MD			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			10-16-68		
			Riverdale, Md.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)		
23a BURIAL, CREMAT ON, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			Oct 18, 1968		Ft Lincoln Cemetery			Colmar Manor, Pro Geo Md.			
24 FUNERAL DIRECTOR						ADDRESS		25a. REC'D BY REG STRAR		25b. REG STRAR'S SIGNATURE	
F. Gasch's Sons						Hyattsville, Md.		OCT 21 1968		<i>Charles Judge</i>	





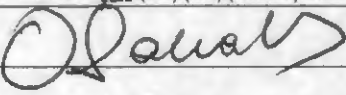
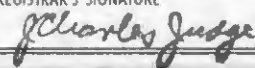
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14978

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

14988

1. DECEASED-NAME (Type or print) <b>Mary A. Woodworth</b>			2a. DATE OF DEATH Month <b>Oct.</b> Day <b>16</b> Year <b>1968</b>			2b. HOUR <b>10:30</b> <sup>A</sup>	
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>Jan. 1, 1884</b>		6. AGE (In years last birthday) <b>84</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Ill.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George's</b> Md.	
10. CITY OR TOWN OF DEATH <b>Cheverly</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo. Gen'l Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>House Wife</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. CITY OR TOWN <b>Prince George's Kent Village</b>	
13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13d. STREET AND NUMBER <b>2818 74th Avenue</b>				
14. FATHER'S NAME First Middle Last <b>Thomas Voyles</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Ella ??</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>213 56 8602</b>		17. INFORMANT Address <b>Pauline Fratantuono Same as # 13</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>402X Hypotension</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebrovascular accident - Cerebral thrombosis.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hypertensive Heart Disease.</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>443X</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that <del>xx</del> (this hospital) attended the deceased from <b>Oct. 8, 1968</b> , to <b>Oct. 16, 1968</b> , that <del>xx</del> (we) last saw the deceased alive on <b>Oct. 16, 1968</b> , and that in <del>xxx</del> (our) opinion death occurred on the date and hour and from the causes stated above <del>xx</del> (we) (did) (did not) view the body after death.							
22b. SIGNATURE 				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>Oct. 16, 1968</b>	
22d. PHYSICIAN'S NAME (Type) <b>Ohannes Sahakyan, M. D.</b>				22e. ADDRESS <b>Prince Geo. Gen'l Hospital, Cheverly, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10/19/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bethel Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Dahlgren Ill</b>	
24. FUNERAL DIRECTOR ADDRESS <b>France's Gasch's Sons Hyattsville, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>OCT 21 1968</b>		25b. REGISTRAR'S SIGNATURE 	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
304A REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR
Baby Girl			Yasler			Oct., 22 1968			11.59 P
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS
Female		White		22 Oct., 1968			— YRS.		IF UNDER 24 HRS. HOURS MIN. 59
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH
Maryland									Pr. Geo., Md.
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Cheverly			Pr. Geo. Gen., Hosp.,						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
Maryland			Pr. Geo.,			Bowie			13e. STREET AND NUMBER 12345 Melling Lane
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Scott Yasler			Margaret Mullany						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atalectasis Neonatorum</u> 7769 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 59 min.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 7625									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (he) (this hospital) attended the deceased from <u>Oct. 22</u> , 19 <u>68</u> , to <u>Oct. 22</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Oct. 22</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>John H. Moling, M.D.</u> DEGREE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 10-23-68	
22d. PHYSICIAN'S NAME (Type) John H. Moling, M. D.						22e. ADDRESS 12107 Linden Lane, Bowie, Md. 20715			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 11/23/68			23c. NAME OF CEMETERY OR CREMATORY Prince Geo. General Hosp.			23d. LOCATION (City or Town) (County) (State) Cheverly, Maryland
24. FUNERAL DIRECTOR <u>HARRY W. PENN, JR.,</u> ADDRESS <u>ADMINISTRATOR</u>			25a. REC'D BY REGISTRAR DATE NOV 29 1968			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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